South African Medical Journal
Suid-Afrikaanse Tydskrif vir Geneeskunde

P.O. Box 643, Cape Town Posbus 643, Kaapstad

Cape Town, 17 November 1956 Weekly 2s. 6d. | Vol. 30 No. 46 | Kaapstad, 17 November 1956 Weekliks 2s. 6d.

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South African Medical Journal
Suid-Afrikaanse Tydskrif vir Geneeskunde
P.O. Box 643, Cape Town — Posbus 643, Kaapstad

Cape Town. 17 November 1956 Weekly 2s. 6d. — Vol. 30 No. 46 — Kaapstad, 17 November 1956 Weekliks 2s. 6d.

PRAKTIESE MOEILIKHEDE MET DIE RADIOLOGIE VAN DIE GROOTBOOG VAN DIE MAAG

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As die 4 illustrasies van die 4 verskillende gevalle ondersoek word, sal dit blyk hoe moeilik dit in die gewone bariummaal mag wees om te besluit in watter gevalle die grootboog van die maag 'n organiese letsel wys en in watter nie. In al 4 die gevalle was die radiologiese beeld min of meer konstant. Die gevalle is operatief gekontroleer.

Indien die kliniese- en laboratorium-ondersoeke in sulke gevalle onseker is, as die gewone bariummaal en gastroskopie nie sekerheid gee nie, en as 'n laparotomie om een of ander rede nie gedoen kan word nie, is daar 'n paar minder bekende metodes van ondersoek wat kortliks bespreek sal word.

GEVALLE

Geval 1

L.D.V., 55-jarige vrou. Bariummaal op 14 Augustus 1954 wys 'n groot, onreëlmatige defek of induiking van die onderste derde van die grootboog van die maag (Fig. 1). Dit word moontlik deur groot, onreëlmatige slymvliesvoue veroorsaak, maar die feit dat die slymvlies langs die res van die grootboog nie besonder grof is nie, is daarteen. 'n Tumor kan nie met sekerheid uitgesluit word nie. Die aard van die defek is dus onseker. Daarby wys die bariummaal ook 'n piloriese ulkus (nie sigbaar op hierdie plaat nie). Die piloriese ‚antrum' is spasties. Lediging is normaal.

Operasie op 17 Augustus 1954 (Prof. J. H. Louw) wys digte vergroeiings tussen die pilorus, voorste buikwand en lewer. Geen afwyking word in die res van die maag of duodenum gesien of gevoel nie. 'n Bilroth I gedeeltelike maagreseksie word gedoen. Die reseksie preparaat wys 'n piloriese ulkus sonder tekens van kwaadaardigheid. Die grootboog wys geen afwyking nie.

Geval 2

L.F., 55-jarige man. Bariummaal op 28 Julie 1955 wys growwe, onreëlmatige maagslymvliesvoue. Langs die boonste derde van die grootboog is 4 of 5 langerige uitstulpings wat waarskynlik hierdeur veroorsaak word. Op die middelste derde van die grootboog is daar 'n groot, konstante nis of pseudo-nis (Fig. 2). Die aard hiervan is nie seker nie maar die volgende differensieële diagnose word voorgestel:

Fig. 1. Geval 1. Onreëlmatige defek of induiking van die onderste derde van die grootboog. Die slymvlies langs die res van die grootboog is nie besonder grof nie.

Fig. 2. Geval 2. 4 of 5 langerige uitstulpings op die boonste derde van die grootboog, en 'n konstante nis of pseudo-nis van die middelste derde.

(i) Maag-ulkus. 'n Goedaardige ulkus mag af en toe op die grootboog voorkom, maar verreweg die meeste van hierdie gevalle is kwaadaardig.[1]

(ii) Ulsererende tumor. 'n Nis op die grootboog mag veroorsaak word deur ulserasie in 'n tumor, maar in hierdie geval word geen egte vullingsdefek langs die nis gesien nie.

(iii) Maagdivertikel. 'n Divertikel op die grootboog is uiters seldsaam. Die meeste maagdivertikels word selde meer as 'n paar cm. van die kardia of pilorus gesien. In 'n reeks van 21 maagdivertikels onlangs deur Sommer en Goodrich[10] beskrywe, was 20 by die kardia.

(iv) Formation cavitaire d'origine dynamique. Letterlik vertaal, beteken hierdie kondisie, wat vir die eerste keer in 1932 deur Moutier[6] beskrywe is, holtevorming wat deur beweging veroorsaak word. Dit kan 'n pseudo-holte of pseudo-nis genoem word, omdat dit konstant aanwesig is in die bariummaal maar geen organiese afwyking word in die patologiese ondersoek gevind nie. In die jongste tyd is etlike van hierdie gevalle beskryf.[9] Moutier was van mening dat die pseudo-holte deur abnormale spiersaamtrekkings veroorsaak word.

Opersasie op 11 Augustus 1955 (Dr. D. J. du Plessis) wys 'n groot tumor van die grootboog van die maag. Sekondêre kliere word naby die porta hepatis gevoel, maar daar is geen verspreiding in die lewer nie. 'n Hoë, subtotale, Polya-tipe gastrektomie en anastomose word gedoen. Patologie (Dr. C. J. Uys, 25 Augustus 1955): Op die grootboog van die maag is 'n groot ulkus, 8 cm. in deursnit, met verdikte, omgerolde rande. Op die kleinboog is daar vergrote limfkliere wat blykbaar deur tumorweefsel aangetas is. Histologies is daar 'n digte infiltrasie van die rand van die ulkus deur ritikulumselle. In sommige limfkliere is die normale patroon verander en verplaas deur plate retikulumselle en enkele eosinofiele. Hierdie verskynsels stem ooreen met 'n retikulumselsarkoom.

Geval 3

K.M., 44-jarige man. Bariummaal op 5 April 1955 wys 'n onreëlmatige vullingsdefek op die middelste derde van die grootboog (Fig. 3). Maagperistaltiek is verminder maar die piloriese

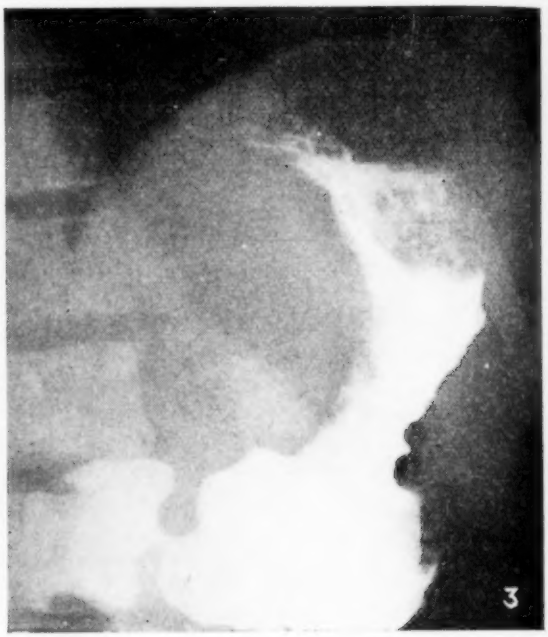

Fig. 3. Geval 3. Onreëlmatige vullingsdefek op die middelste derde van die grootboog.

saamtrekkings en lediging is normaal. Die defek is nie skerp begrens nie en mag veroorsaak word deur groot en onreëlmatige slymvliesvoue, wat gewoonlik in hierdie deel van die maag gesien word, of deur 'n tumor.

Operasie op 12 April 1955 (Prof. J. H. Louw) wys 'n groot tumor van die maag wat tot by die fundus strek, die transversale mesokolon aantas, en sekondêre kliere by die hilum van die milt. Die tumor is nie verwyderbaar nie. Histologiese seksie van een van die limfkliere wys taamlik goed gedifferensieërde adenokarsinoom-selle, wat ooreenstem met 'n primêre oorsprong in die maag.

Gaval 4

G.A., 60-jarige man. Bariummaal op 30 Maart 1955 wys 'n onreëlmatigheid van die onderste derde van die grootboog, wat oënskynlik uit 'n vlak vullingsdefek bestaan, met 3 of 4 langerige uitstulpings in die middel daarvan (Fig. 4). Die peristaltiek, piloriese saamtrekkings en lediging van die maag is normaal. Die differensieële diagnose tussen buitengewoon growwe slymvliesvoue en tumor van die grootboog kan nie met sekerheid gemaak word nie.

Operasie op 1 April 1955 (Prof. J. H. Louw) wys geen afwyking in die maag of duodenum nie. Daar word ook geen afwyking in hierdie organe gevoel nie. Die sakderm is in die boonste regterkwadrant aan die lewer vas deur vergroeiings, wat losgemaak word. Die maag en alle ander buikorgane is normaal.

BESPREKING

In gevalle 1 en 4 was daar geen organiese afwyking wat vir die onreëlmatigheid van die grootboog verantwoorde-

Fig. 4. Geval 4. 3 of 4 langerige uitstulpings in die middel van 'n vlak defek van die onderste derde van die grootboog.

lik was nie, in geval 2, het 'n retikulumsel-sarkoom, en in geval 3, 'n adeno-karsinoom dit veroorsaak. In geen van hierdie gevalle was dit moontlik om in die gewone bariummaal met sekerheid vas te stel of daar 'n organiese afwyking van die grootboog aanwesig was of nie. 'n Paar soortgelyke gevalle is onlangs deur Lundie, Scott en Mackenzie[5] beskrywe. Hulle noem 3 gevalle waar spasme van die grootboog 'n pseudo-nis veroorsaak het, en een waar plaaslike spasme verkeerdelik as 'n karsinoom beskou is. Dit blyk dus dat daar 'n moontlikheid is dat onreëlmatige spastiese kondisies van die grootboog, van onsekere oorsprong, verwar kan word met organiese letsels. Die teenoorgestelde, nl. dat 'n kwaadaardige nis, karsinoom of sarkoom van die grootboog verkeerdelik as 'n buitengewone spiersaamtrekking geïterpreteer kan word, is 'n groter wesenlike gevaar. Hierdie moeilikheid word gewoonlik nie op die kleinboog teengekom nie, om die volgende redes: (i) In alle normale gevalle is die grootboog, en veral sy boonste gedeelte, in meerdere of mindere mate onreëlmatig a.g.v. die slymvliespatroon van die maag, terwyl die normale kleinboog glad is. (ii) Daar is nog nie 'n geval beskryf, sover ons weet, waar 'n konstante nis op die kleinboog nie 'n organiese letsel aangedui het nie. Die aan- of afwesigheid van 'n organiese afwyking op die kleinboog kan dus sonder moeite in die roetine bariummaal vasgestel word, terwyl dit nie altyd die geval is op die grootboog nie.

In hierdie onsekere gevalle sou die volgende metodes van ondersoek moontlik verdere inligting gee:

1. *Gelyktydige pneumoperitoneum en bariummaal.* Meneghini en de Marchi[6] het aangetoon dat die dikte van die maagwand goed sigbaar word met so 'n ondersoek. 'n Sagteweefsel tumor van die maag kan dus goed gesien word tussen die barium binne en die lug buite die maag. Hulle beweer dat die juiste posisie en grootte van die massa op hierdie manier vasgestel kan word.

2. *Waterstof peroksied in die bariummengsel.* Die gebruik van H_2O_2 in toetse vir bloeding is lankal bekend, en berus op die feit dat H_2O_2 deur hemoglobine opgebreek word met vrysetting van suurstof. Leukosiete het dieselfde uitwerking. Klami[4] het op die gedagte gekom om H_2O_2 by sekere X-straal kontrasstowwe te voeg, en meng dus 3% H_2O_2 in water met die gewone barium. Waar so 'n mengsel met ulserasie in aanraking kom, bv. in die maag, word suurstof vrygesit, en die skuim kan soms op plate gesien word. Die woord ‚soms' word benadruk, omdat Klami se resultate sover dit die maag betref, nie altyd ewe betroubaar was nie. Soos te verwagte, was daar in etlike gevalle van bloederige gastritis ook skuimvorming. In die slukderm is betroubaarder resultate verkry. Die metode is nog nie ten volle getoets nie, en bied geleentheid vir verdere navorsing.

3. *Die elektrogastrograaf* (*EGG*). Met hierdie apparaat, wat min of meer volgens dieselfde prinsipe as die elektrokardiograaf werk, word elektriese studies van die maag verkry. Dit is vir die eerste keer as 'n kliniese hulpmiddel deur Goodman[2] in 1942 gebruik. Die apparaat is verder ontwikkel en in 1954 beskryf deur Morton,[7] professor in sjirurgie aan die McGill Universiteit in Montreal. Twee elektrodes word gebruik, die een op die vel van die regter delto-pektorale gebied, terwyl die tweede ingesluk word. In alle dele van die normale maag is die ritme dieselfde, hoewel die hoogte van die kurwe vermeerder hoe nader die maagelektrode aan die pilorus is. Die frekwensie is omtrent drie siklusse per minuut. Spesiale vorms van peristaltiek, bv. honger of pilorise obstruksie, mag 'n stadiger ritme, bv. een siklus per minuut gee.

Volgens Morton kan daar nie duidelik met die EGG tussen maag-en duodenale-ulkusse gedifferensieër word nie, hoewel dit moontlik is om tussen aktiewe en onaktiewe ulkusse te onderskei. Ulkus-gevalle word dus verdeel in aktiewe en onaktiewe gevalle. Die onaktiewe ulkusse gee 'n normale kurwe. In 'n aktiewe maagulkus is die kurwe byna altyd reëlmatig met 'n matige vermeerdering in hoogte en vinniger frekwensies op die oorspronklike kurwe. In 'n aktiewe duodenale-ulkus is daar 'n hoogtevermeerdering en 'n geringe onreëlmatigheid in ritme. 'n Karsinoom gee 'n kurwe wat altyd onreëlmatig is in hoogte en in ritme. Morton het 40 gevalle van bewese maagkarsinoom ondersoek. In 3 was die kurwe nie tipies van karsinoom nie, en sou die diagnose nie met die EGG gemaak kon word nie.

Goodman[3] en sy helpers het later hulle ondervindings met die EGG oor 'n periode van 5 jaar beskrywe, en kom tot die gevolgtrekking dat 'n karsinoom 'n duidelike vermindering van die elektriese impuls kan gee, of 'n algehele onreëlmatigheid, of 'n kombinasie van bogenoemde twee karaktertrekke. Hulle bevindings is baie

minder bevredigend as dié van Morton. Uit 60 normale gevalle het die EGG bv. 'n normale kurwe in slegs 26 gevalle gewys, terwyl die kurwe in 26, soortgelyk aan dié van 'n aktiewe ulkus was, en in 8, soortgelyk aan 'n karsinoom. In 46 gevalle van karsinoom was daar één normale kurwe, 19 sou tipies van ulkus wees, en slegs 26 tipies van karsinoom. Dit blyk dus dat die EGG op die huidige tydstip taamlik onbetroubare resultate lewer. Of dié metode van ondersoek verbeter kan word, moet nog gesien word.

Uit die gevalle wat beskryf is, blyk dit weer dat wanneer daar enigsins twyfel bestaan oor die grootboog van die maag, ten spyte van al die ondersoeke tot ons beskikking, daar nie versuim moet word om 'n laparotomie te verrig nie, as die pasiënt se toestand dit toelaat.

OPSOMMING

4 Gevalle word beskryf waarin die bariummaal 'n buitengewone onreëlmatigheid van die grootboog van die maag gewys het. In geen van die gevalle kon 'n pre-operatiewe diagnose met sekerheid gemaak word nie, hoewel 'n differensieële diagnose voorgestel is. Operatief was 2 van die gevalle normaal, een was 'n adeno-karsinoom en die ander 'n retikulumsel-sarkoom van die grootboog. Etlike soortgelyke gevalle is onlangs in die buitelandse literatuur beskrywe.

Die kondisie bekend as *formation cavitaire d'origine dynamique* word kortliks bespreek, en ook die tegniek van gelyktydige pneumoperitoneum en bariummaal, H_2O_2 in die bariummengsel, en die elektrogastrograaf.

SUMMARY

4 Cases are described in which the barium meal showed an unusual irregularity of the greater curvature of the stomach. In none of these cases was it possible to come to a definite pre-operative diagnosis, although a differential diagnosis was suggested. Laparotomy showed that 2 of the cases were normal, 1 was an adenocarcinoma and the other a reticulum-cell sarcoma of the greater curvature. Several similar cases have recently been reported in the literature.

The condition known as *formation cavitaire d'origine dynamique* is discussed briefly, and short descriptions are given of the technique of simultaneous pneumoperitoneum and barium meal, H_2O_2 in the barium mixture, and the electrogastrograph.

Die skrywers wil graag die Superintendent van Groote Schuurhospitaal, asook prof. J. H. Louw, dr. D. J. du Plessis, dr. L. Mirvish en dr. C. J. Uys bedank vir toestemming om gebruik te maak van die gegewens.

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WORLD MEDICAL ASSOCIATION

At its 10th General Assembly, held in Havana, Cuba, on 9-15 October 1956, the WMA elected the following officers: *President* 1956-57—Dr. Jose A. Bustamante (Cuba). *President-elect* 1956-57—Dr. Ahmet Rasim Onat (Turkey). *Treasurer* 1956-59—Dr. Ernst Fromm (Germany). *Members of Council* 1956-59—Dr. Gunnar Gundersen (USA), Dr. Marcel Poumailloux (France), Dr. S. C. Sen (India) and Dr. Lorenzo Garcia-Tornel (Spain). The Council of WMA elected the following officers for 1956-57: *Chairman of Council*—Dr. Lorenzo Garcia-Tornel (Spain). *Vice-chairman of Council*—Dr. L. R. Mallen (Australia).

The Chairman of Committees for 1956-57 include: *Editorial Board*—Dr. Austin Smith (USA). *International Liaison*—Dr. Jean Maystre (Switzerland). *Medical Education*—Sir Lionel Whitby (UK). *Medical Ethics*—Dr. P. Glorieux (Belgium). *Miscellaneous Business*—Dr. Otto Rasmussen (Denmark). *Planning and Finance*—Dr. T. C. Routley (Canada). *Social Security*—Dr. Dag Knutson (Sweden) and Dr. Rolf Schloegell (Germany).

Regional Secretaries were appointed for Asia, Australasia, Europe and Latin America. The following officials of the World Medical Journals were appointed: *Executive Editor*—Dr. Austin Smith (USA). *Associate Editor*—Dr. Stanley S. B. Gilder (Canada). *Business Manager*—Dr. Louis H. Bauer (USA).

The following Liaison Officers were appointed: Dr. Jean Maystre (Switzerland), Dr. P. Glorieux (Belgium) and Dr. V. A. Fenger (Denmark).

Amongst the resolutions taken at the 10th General Assembly were the following:

International Medical Law. 'It is the primary function of the medical doctors of the world to formulate any code of International Medical Law and the World Medical Association is the only organization that can speak for the doctors of the world.'

Traffic Accidents. 'Whereas the death and maiming of humanity throughout the world is increasing rapidly each year, and whereas it is the duty and responsibility of the medical profession in every country of the world to assist in the preservation and maintenance of human life, therefore be it resolved: That the World Medical Association recommend to its member associations that they cooperate with other agencies and authorities within their country to whatever degree is possible and necessary in a concentrated endeavour to save and preserve human life.'

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EDITORIAL

TETANUS IN SOUTH AFRICA

Tetanus has long presented a challenge to preventive medicine. For obvious reasons it looms large in military hygiene, and in civilian life also it is responsible for much preventible mortality. It is of special importance in South Africa, where the disease occurs more frequently than in most countries. In the 3 years 1946-48 the tetanus deaths in South Africa numbered 563, representing an annual death rate of 16·1 per million living, which is 10 times as great as in England and Wales, where the deaths from this cause in the same 3 years numbered 203, equivalent to an annual death rate of 1·6 per million.[1] No great improvement in this matter has taken place in either country since that time.

It is now many years since passive immunization against the exotoxin of *Cl. tetani* was introduced for use in persons who having received a wound were liable to tetanus infection. During the 1914-18 war the injection of all wounded with antitetanic serum reduced the incidence of tetanus in a few months from about 8 per 1,000 to 1 per 1,000, and later to a still lower level.[2] This form of immunization is extensively used in civilian practice, and no doubt, where it is applied, potential cases of tetanus are prevented. It is evident, however, from the figures given above, that the prevention of tetanus in the civilian population is a relative failure. A reason for this is that people with apparently trivial wounds are commonly left uninoculated, or are not seen by a doctor at all. Moreover, cases of tetanus are not uncommon in which no history of an external wound is obtainable. It is to be noted also that tetanus neonatorum is responsible for more than half of the deaths from tetanus; in the 5 years 1946-50, 57% of all tetanus deaths in South Africa were of infants less than a month old.[1] The prevention of neonatal tetanus presents a different set of problems to tetanus in older children and adults.

The use of antitetanic serum is attended with certain inherent disadvantages. The effective protection conferred by a first dose of 1,500 units lasts for less than 4 weeks, and the period may be as short as 3 days in persons who had a prophylactic injection in the past.[2,4,5] Moreover the potential anaphylactic effects of the

VAN DIE REDAKSIE

KAAKKLEM IN SUID-AFRIKA

Kaakklem verteenwoordig reeds lank 'n uitdaging vir voorbehoedende geneeskunde. Om klaarblyklike redes neem dit 'n belangrike plek by militêre higiëne in en ook by burgerlike lewe is dit verantwoordelik vir 'n groot aantal sterfgevalle wat verhoed kon word. Dit is van spesiale belang in Suid-Afrika waar die siekte meer dikwels as in meeste ander lande voorkom. Gedurende die 3 jaar 1946-48 het die sterfgevalle weens kaakklem in Suid-Afrika 563 beloop, wat 'n jaarlikse sterftesyfer van 16·1 per miljoen lewendes verteenwoordig. Dit is 10-maal groter as wat dit in Engeland en Wallis is, waar die sterfgevalle weens hierdie oorsaak gedurende dieselfde 3 jaar, 203 beloop het, wat gelykstaan met 'n jaarlikse sterftesyfer van 1·6 miljoen.[1] Geen noemenswaardige verbetering van hierdie saak het sedertdien in enigeen van die lande plaasgevind nie.

Dit is nou al baie jare sedert passiewe immunisering teen die eksotoksien van *Cl. tetani* ingestel is vir gebruik by persone wat, wanneer hulle 'n wond opdoen, onderhewig is aan kaakklem-besmetting. Gedurende die 1914-18 oorlog het die inspuiting van alle verwondes met antitetanus-serum die voorkoms van kaakklem binne 'n paar maande van ongeveer 8 per 1,000 tot 1 per 1,000 verminder en later, tot nog 'n laer peil.[2] Hierdie wyse van immunisering word op 'n groot skaal in burgerlike praktyke gebruik en daar bestaan geen twyfel nie dat, waar dit aangewend word, potensiële gevalle van kaakklem verhoed word. Uit die syfers hierbo gegee, is dit egter duidelik dat die voorkoming van kaakklem by die burgerlike bevolking 'n relatiewe mislukking is. 'n Rede hiervoor is dat mense met oënskynlik niksbeduidende wonde gewoonlik nie ingeënt word nie, of glad nie deur 'n dokter gesien word nie. Bowendien is gevalle waar geen geskiedenis van 'n uitwendige wond te vinde is nie, glad nie ongewoon nie. Daar moet ook opgelet word dat tetanus neonatorum vir meer as die helfte van die sterfgevalle weens kaakklem verantwoordelik is; van al die kaakklem-sterfgevalle wat gedurende die 5 jaar 1946-50 in Suid-Afrika voorgekom het, was 57% daarvan van suigelinge minder as 'n maand oud.[1] Die voorkoming van kaakklem by pasgebore kinders lewer 'n ander groep probleme op as kaakklem by ouer kinders en volwassenes.

Die gebruik van antitetanus-serum gaan gepaard met sekere inherente nadele. Die effektiewe beskerming verleen deur 'n eerste dosis van 1,500 eenhede, duur vir minder as 4 weke, en die periode mag so kort soos 3 dae wees by persone wat 'n voorbehoedende inspuiting

horse serum are not negligible. Reactions are not rare, and may be severe, or, occasionally, fatal. Moynihan[2,4] concludes from his investigations that the intradermal test for sensitivity, which is used at many hospitals before the antitoxin is injected, is unreliable, and that a positive reaction leads to the unnecessary withholding of the antitoxin from many patients who need prophylaxis. He advises that the intradermal testing for sensitivity to horse serum should be replaced by the 'trial dose' method of Laurent and Parish,[5] which consists of a preliminary subcutaneous injection of a small dose of the serum to test the patient's reaction before the full dose is given.

Active immunization with tetanus toxoid, if adequately practised, affords a more certain way of preventing tetanus, though probably not practicable against tetanus neonatorum. In World War II it was used with remarkably successful results. In the British Army 2 injections of toxoid were given at intervals of not less than 6 weeks, followed by a reinforcing dose at yearly intervals. If a man was wounded he was given antitoxin, but in the American Army a further dose of toxoid was given instead. The results by both methods were highly satisfactory.[2] The Army Pathology Advisory Committee[2,5] advises that a person who has received the 2 injections at an interval of 6-12 months is to be regarded as actively immunized for 6 months; and that one who has received 3 injections at a first interval of 6 months and a second of 6-12 months, is to be considered as immunized for 5 years. A reinforcing injection should be given every 5 years.

This system of active immunization is eminently applicable to the civilian population. Active immunization against diphtheria, though not yet practised in South Africa as effectively as it ought to be,[6] appears to be almost universally applied to the babies of the more intelligent classes and to a substantial proportion of the babies of all classes in some of our larger towns. Two or three injections are needed for effective initial immunization against diphtheria, and the immunizing doses may well be combined with tetanus toxoid so as to obtain an initial immunization against tetanus, which can be rendered effectively life-long by 5-yearly reinforcing doses.

The prevention of neonatal tetanus appears rather to be a problem of clean midwifery and neonatal care.

1. Slome, R. (1954): S. Afr. Med. J., **28**, 473.
2. Editorial (1956): Brit Med. J., **2**, 348.
3. Moynihan, N. H. (1956): *Ibid.*, **1**, 260.
4. Littlewood, A. H. M., Mant, A. K. and Wright, G. P. (1954): *Ibid.*, **2**, 444.
5. Barr, M. and Sachs, A.: *Army Pathology Advisory Committee Report*, W.O. Code No. 11262.
6. Bokkenheuser, V. and Heymann, C. S. (1954): S. Afr. Med J., **28**, 685.

in die verlede gehad het.[2,4,5] Bowendien is die potensiële anafilaktiese gevolge van die perde-serum nie onbeduidend nie. Reaksies is nie seldsaam nie en mag ernstig of, af en toe, noodlottig wees. As gevolg van sy navorsings het Moynihan[2,4] die tot gevolgtrekking gekom dat die binnehuidse toets vir gevoeligheid, in baie hospitale gebruik voor die antitoksien ingespuit word, onbetroubaar is, en dat 'n positiewe reaksie daartoe lei dat die antitoksien onnodiglik weerhou word van baie pasiënte wat voorbehoeding nodig het. Hy raai aan dat die binnehuidse toets vir gevoeligheid tot perde-serum vervang behoort te word met die *'trial dose'*-metode van Laurent en Parish,[5] wat bestaan uit 'n voorafgaande onderhuidse inspuiting met 'n klein dosis van die serum om die pasiënt se reaksie te toets, voordat die volle dosis gegee word.

Aktiewe immunisering met kaakklem-toksoïed, as dit doeltreffend beoefen word, verskaf 'n sekerder manier om kaakklem te voorkom, alhoewel dit waarskynlik nie teen tetanus neonotorum bruikbaar is nie. In die Tweede Wêreld Oorlog is dit met opvallend suksesvolle resultate gebruik. In die Britse leër is 2 toksoïed-inspuitings met tussenposes van nie minder as 6 weke nie, gegee, gevolg deur 'n versterkende dosis met jaarlikse tussenposes. As 'n man gewond was, is antitoksien aan hom gegee, maar in die Amerikaanse leër is 'n verdere dosis van toksoïed in die plek daarvan gegee. Die resultate verkry met beide metodes was hoogs bevredigend. Die Army Pathology Advisory Committee[2,5] raai aan dat 'n persoon wat 2 inspuitings met 'n tussenpose van 6-12 maande ontvang het, beskou moet word as aktief geïmmuniseerd vir 6 maande; en dat een wat 3 inspuitings met 'n eerste tussenpose van 6 maande en 'n tweede van 6-12 maande gekry het, beskou moet word as geïmmuniseerd vir 5 jaar. 'n Versterkende inspuiting behoort elke 5 jaar gegee te word.

Hierdie stelsel van aktiewe immunisering is besonder toepaslik op die burgerlike bevolking. Dit skyn of aktiewe immunisering teen witseerkeel, alhoewel dit nog nie in Suid-Afrika so effektief beoefen word soos dit hoort nie,[6] amper universeel vir babas van die meer intelligente klasse en vir 'n aansienlike proporsie van die babas van alle klasse in sommige van ons groter dorpe gebruik word. Twee of drie inspuitings is nodig vir effektiewe aanvangs-immunisering teen witseerkeel en die immuniserende dosisse mag net so wel met kaakklem-toksoïed gekombineer word om sodoende 'n aanvangs-immunisering teen kaakklem te verkry, wat lewenslank effektief gemaak kan word deur 5-jaarlikse versterkende dosisse.

Dit skyn nogal of die voorkoming van kaakklem by pasgebore babas 'n probleem van sindelike verloskunde en nageboortelike sorg is.

1. Slome, R. (1954): S. Afr. T. Geneesk., **28**, 473.
2. Van die Redaksie (1956): Brit. Med. J., **2**, 348.
3. Moynihan, N. H. (1956): *Ibid.*, **1**, 260.
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URETHRO-VAGINAL AND VESICO-VAGINAL FISTULAE*

A SUMMARY OF 57 CASES ENCOUNTERED IN THE GROOTE SCHUUR HOSPITAL, CAPE TOWN JANUARY 1952 TO JULY 1956

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An opening connecting the bladder or urethra or both to the vagina is a most distressing anatomical defect. It is a source of great discomfort to the patient mentally and physically. The lot of a woman who is for ever wet and smelling of decomposed urine must be one of the hardest on earth to bear. The very thought that in most cases it is a result of inferior practice of medicine—be it obstetrics, gynaecology, surgery or radiotherapy—is a cause for great concern. As a general rule it may be stated that the better the medical services in a given community the lower is the incidence of vesico-vaginal fistula. A high incidence of vesico-vaginal fistula is a sad reflection on obstetrical services. In certain parts of South Africa the incidence of vesico-vaginal fistula is appalling. This is not necessarily the result of inferior medicine; it is often due to great distances, abject poverty and apathy—or really antipathy—to modern methods. In dealing with persons who still firmly believe in their witch-doctors this attitude of mind can be understood. The medical practitioner is only summoned when almost all is lost. However, a change of attitude in the Bantu is taking place at an ever increasing rate. This is evidenced by an almost overwhelming increase in attendance at antenatal clinics and a readiness for medical consultation in sickness. It is only human that great difficulty is met with in severing bonds with age-old magical and mystical practices. Few people are completely devoid of superstition. It is therefore understandable that the lower the level of true education the tighter is the clinging to magical aids.

ETIOLOGY

Although a major cause, *inferior obstetrics* is not responsible for all vesico-vaginal fistulae. In Johannesburg, Charlewood[1] and Lavery[3] state that with few exceptions their cases resulted from difficult deliveries. Chassar Moir's figures,[7] on the other hand, correspond with those of Norman Miller,[6] and show that in the UK and the USA not only are fistulae uncommon but most of them arise as complications following upon operative procedures. Roughly one-third of their total number of fistulae were of obstetrical origin and two-thirds resulted from operative procedures. The series I am dealing with is small, but it is of interest to note that in percentage the figures for Whites roughly correspond with those of Moir and of Miller, and for the Bantu with those of Charlewood and of Lavery. In our Coloured people an intermediate figure is found.

* A paper read at a meeting of the Cape Town Sub-groups of the Obstetrical and Gynaecological and Urological Societies, August 1956.

In Table I the 57 cases in the series now presented are classified by race and etiology. The figures for the 3 races may well be taken as a reflection of different social levels.

TABLE I

Race	*Post-operative*	*Labour*	*Inflammatory*	*Total*
White	5	2	—	7
Coloured	7	19	3	29
Bantu	0	20	1	21
All Races	12	41	4	57

It is to be stressed that vesico-vaginal fistula is a very unusual labour complication in urban areas. With very few exceptions the Bantu women in this series developed their labour sequelae at a great distance from medical aid in their Territories, viz. the Transkei and Ciskei. All but a few of the total cases of all races came from outlying areas.

Sloughing and *trauma*, or a combination of the two, are the main causes of vesico-vaginal fistulae.

Sloughing

Sloughing may be due to:

(*a*) *Continuous and excessive stretching of the base of the bladder.* In normal labour, the bladder base, being closely attached to the cervix, is drawn up into the abdomen when cervical effacement and dilatation occur, and overrides the presenting part. Should the presenting part take an abnormally long time descending or should it become impacted during the second stage, the excessive stretching will materially interfere with the blood supply to the base of the bladder. This interference will be aggravated by the gradual distension of the bladder with urine, for both labour and the impaction of the presenting part interfere with the act of micturition, the former physiologically and the latter mechanically. No stretch of imagination is required to picture the result.

(*b*) *Pressure* of the presenting part, usually the foetal head, against the symphysis pubis for an abnormally long time will damage the soft structures caught between these objects. The brunt of the destruction will therefore fall upon the urethra and the neck of the bladder. It can readily be understood that, if the second stage has been long and possibly static, the irreversible damage may be formidable; and a large vesico-vaginal fistula, with absence of the urethra, may be found at the time of the aided delivery, or developing soon after.

Sloughing of a portion of the bladder wall as a *post-operative* complication is fortunately not commonly

found. After extirpation of the uterus, when sewing up the vaginal vault, active attention should be paid in order to avoid stitches failing to catch up and thus *strangulating a small portion of the bladder wall.* The sloughing that takes place if this occurs will present itself by a leakage of urine starting about the 5th post-operative day. The same applies to vaginal hysterectomies and repairs; faulty concentration may lead to inferior technique, with deleterious results to the patient. After the larger pelvic operations like radical hysterectomy and pelvic lymphadenectomy,.or posterior exenteration, not only is the blood supply of the bladder interfered with to a major degree by the very nature of these operations, but the supports to the bladder, especially in the posterior exenteration, are removed. In our unit, fortune has smiled upon the patients undergoing the Wertheim type of operation, and not one of a series of 97 developed a vesico-vaginal fistula.[4] Of the 12 patients who underwent posterior exenteration, 2 were complicated by vesical fistula (no vagina being left).[4]

On the other hand, *abscess formation* in the region operated upon severely interferes with the local blood-supply. Rupture of an abscess situated between the bladder wall and the vagina, if both organs are severely affected locally, will obviously result in fistula formation. The time of onset of this type of catastrophe in one patient I saw was on the 12th post-operative day. The doctor in charge (and the patient) gave the information that she ran a slight temperature after a total hysterectomy. On the 12th day a little abscess burst into her vagina. After this mishap she was completely incontinent of urine. *Primary inflammatory* causes of vesico-vaginal fistulae are unusual. Three patients in this series gave stories justifying such a diagnosis. The primary lesions in 2 seem to have been urethral diverticuli, because in each case the fistula was found extending from the urethra, through a diverticulum, to the vagina. With excision of the fistulous tract, together with the diverticulum, cure was effected. In one of these patients the following was the sequence of events: She was admitted suffering from an acute abdomen due to a diverticulitis. The abscess burst, producing a vesico-colic fistula. This fistula was operated upon and cured. She then developed, and burst, a peri-urethral abscess, which followed in the wake of the passage of faeces through the urethra. The second attempt at repair of the urethro-vaginal fistula (after excision of the diverticulum) was successful.

Neoplastic infiltration producing fistulae requires no elaboration. Few of these were seen, and they are not included in this series. *Irradiation* fistulae in this unit are very rare. I have not seen one during the period under discussion. This fact is no doubt due to good judgment on the part of our radiotherapists and to the subjection of patients with cervical carcinomatous involvement of the bladder to major surgical procedures.

Trauma

Direct obstetrical instrumental injury of the bladder or penetrating the wall of the urethra are inferior manipulations not warranting discussion. Should craniotomy or embryotomy be indicated, great care must be exercised, for the *spicules of foetal bone* may be knife-edge sharp. Direct injury to the bladder during a difficult *pelvic* operation is unusual. When this does occur, however, all that is required is an immediate repair together with 'bolstering' sutures, followed by continuous post-operative bladder-drainage. A vesico-vaginal fistula is rarely produced by an *accident.* A patient attending the gynaecological out-patient department for her abdominal pain gave a history of having been knocked down by a motor car whilst she was riding her bicycle many years ago, i.e. as a young girl. Amongst her many injuries it was found that a piece of metal had stuck into her bladder *via* the vagina. The fistula had been successfully repaired soon afterwards. *Intercourse* is a major problem after the operation of successful repair of vesico-vaginal fistula. One of my patients had her fistula repaired on 3 occasions. She volunteered that no sooner had she broken continence (despite contrary advice) than complete urinary incontinence was once more established. Of the 3 failures encountered in the Bantu (Table II) one patient was completely continent when she left hospital but was admitted 3 months later as an emergency suffering from an incomplete abortion. She stated that she had become completely incontinent one month after leaving hospital.

SYMPTOMS AND SIGNS

The symptoms and signs of this condition are usually so painfully obvious that they need hardly be mentioned. The diagnosis may almost be made before the patient is seen. An ammoniacal odour in the out-patients' department or in the ward immediately draws attention to the unfortunate sufferer. The patient usually dates her urinary incontinence to a labour, to an operation, or during the period of convalescence. In individuals suffering from advanced cancer, the usual discharge, bleeding and possible pain may be associated with the development of urinary leakage. Small fistulae may give rise to diagnostic problems: they are to be differentiated from patent urethral incontinence, uretero-vesical fistulae and urethral diverticuli. A good history, together with the usual 3-swab test (3 swabs are placed in the vagina, methylene blue is injected into the bladder, and the swabs are withdrawn; the one stained locates the fistula) and a thorough examination under anaesthesia, possibly aided by the injection of a dye into the bladder at that time will serve to make a positive diagnosis.

TREATMENT

It is sad to reflect that if labour were properly conducted and the proper technique employed in pelvic operations, vesico-vaginal fistula would hardly exist. However, if a fistula is present, its cure immediately demands more team-work between medical and nursing staffs than in most other surgical problems. Although pre-operative and operative principles have to be rigidly observed, it is in the post-operative period especially that the danger of a break-down lies. The

nursing staff should be fully conversant with their importance in the team.

Pre-operative Treatment

Pre-operative treatment consists in dealing with any condition which might interfere with wound healing, e.g. syphilis, vitamin or protein deficiency states, the administration of small doses of oestrogen in post-menopausal women, the rendering of the urine sterile and acid in order to dissolve the crusts around the perineal region and in the vagina, and making sure that no bladder stone is present.

In addition, if the fistula is large, ureteral orifices should be located in order to avoid damage to them during the operation or their possible inclusion in

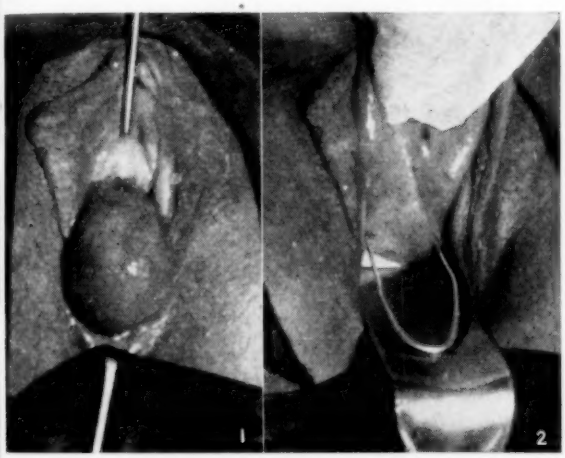


Fig. 1. Bladder wall telescoped through vesico-vaginal fistula.

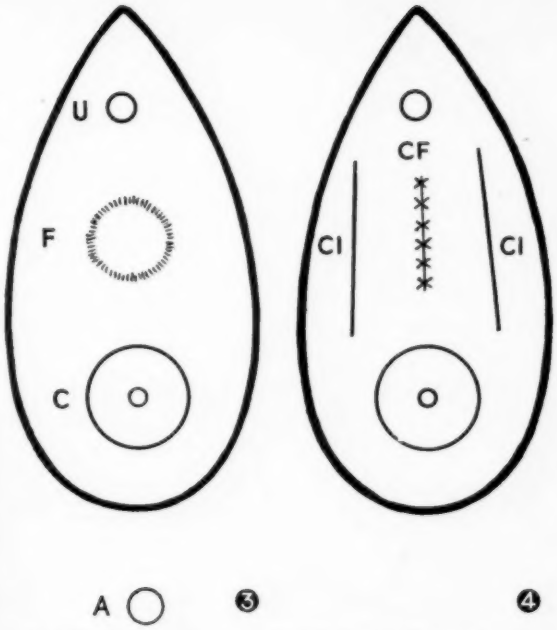
Fig. 2. The points of a bent probe inserted into the ureteric orifices.

suturing. Figs. 1 and 2 caricature this point. In Fig. 2 the two ends of a bent probe are inserted into the ureteric orifices. The patient's blood should be grouped, since with large fixed fistulae the operation may be associated with brisk bleeding.

Operative Treatment

In the operative treatment two main principles must be observed, viz. the rawed edges of the fistula must be apposed, and interference with wound healing must be prevented. The nature of the operation depends upon the size and situation of the fistula. Marion Sims's method of excising the scarred rim and suturing the raw edges is both a simple and an effective method of treatment, as is amply demonstrated by Mahfouz,[5] Moir,[7] Charlewood[1] and Lavery.[3] This is the operation of choice for the small or mobile vesico-vaginal fistula. Should there be the slightest evidence of tension surrounding the suture line, appropriate counter-incisions are made (Figs. 3 and 4).

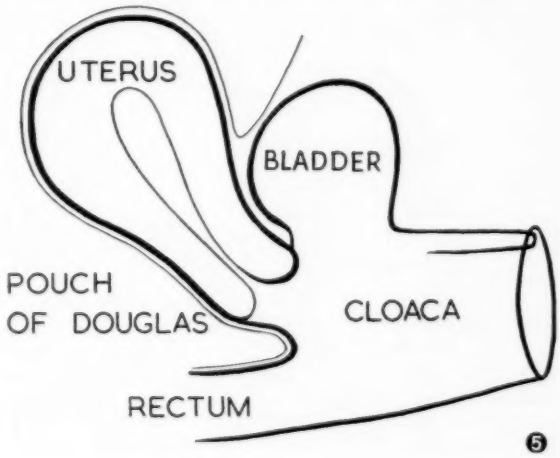
Difficulty is immediately encountered if a large, hard, fixed fistula is present. Once again the scarred

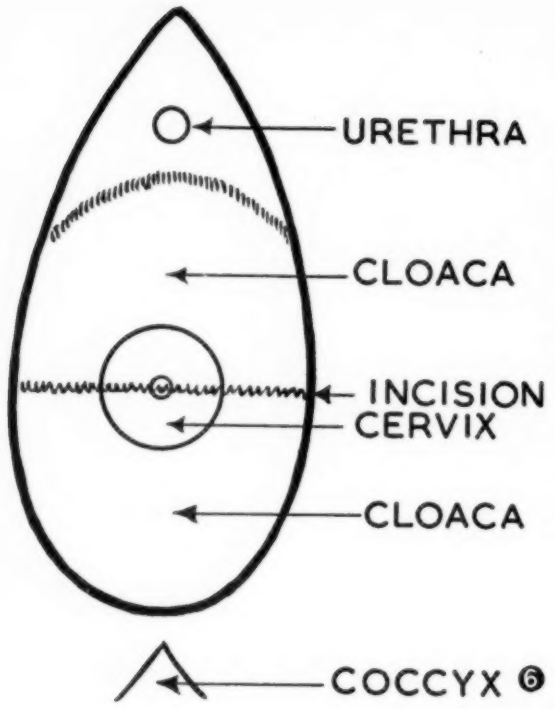


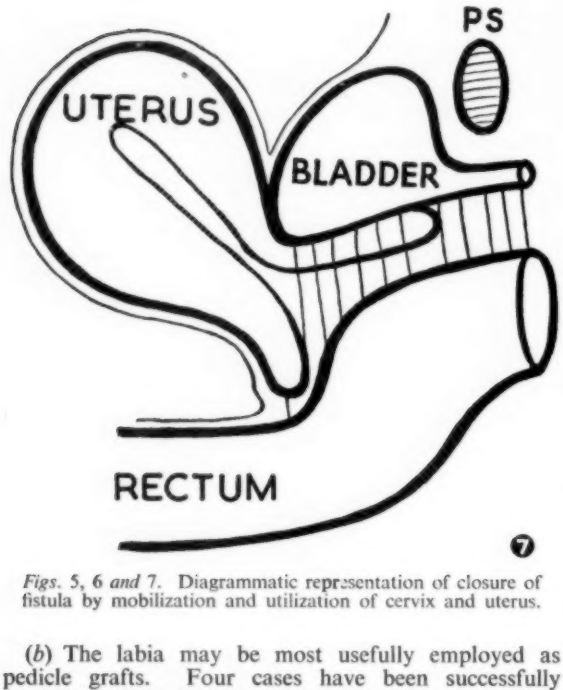
Figs. 3 *and* 4. Diagram showing closing of fistula, with counter-incisions. U=urethra, F=fistula, C=cervix, A=anus, CF=closed fistula, CI=counter-incision.

rim is excised. Schuchardt's incision might be employed for proper exposure of the field. The fistula may be of such dimensions as to make approximation of its edges impossible. There are various ways of overcoming this difficulty. Neighbouring structures may be used effectively, viz.:

(*a*) Mobilizing and utilizing the cervix and uterus (Figs. 5, 6 and 7). Two cases were effectively treated by adopting these measures. In a third patient even these drastic measures proved to be ineffective. She had neither bladder base, nor urethra, nor perineum.







Figs. 5, 6 *and* 7. Diagrammatic representation of closure of fistula by mobilization and utilization of cervix and uterus.

(*b*) The labia may be most usefully employed as pedicle grafts. Four cases have been successfully treated by 'swinging' the labium into the vagina, thus closing the fistula (Fig. 8). The latter operation should be employed more frequently and the former hardly at all. The local condition in these cases requires thorough appraisal and much weighing up before operative procedures are instituted.

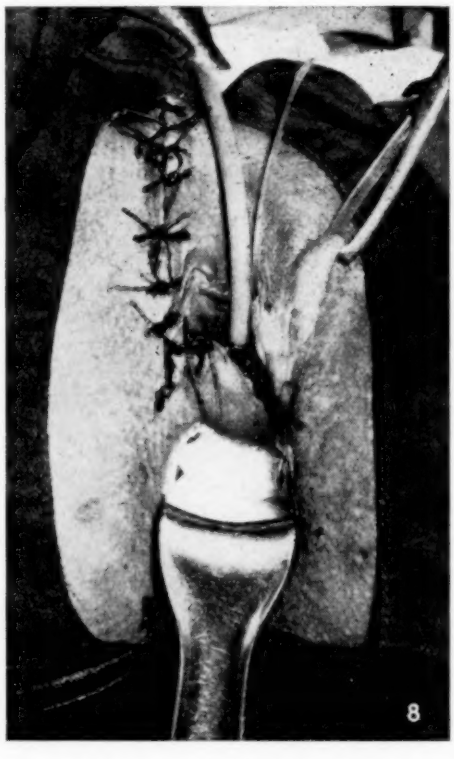


Fig. 8. Pedicle of skin 'swung' into vagina in order to assist in closing the fistula. Note the polythene tube next to the catheter. This tube was inserted into the ureteric orifice.

(*c*) Ingelman-Sundberg[2] dissects out a portion of gracilis muscle, making sure of conserving its blood supply, swings it through the obturator foramen and stitches it to the prepared raw edges of the fistula.

(*d*) M. van Bouwdyk Bastiaanse showed a film at the 1st World Obstetrical and Gynaecological Congress, Geneva, 1952, of an operation in which he mobilizes and closes the large vesico-vaginal fistula, then opens the patient's abdomen, mobilizes the omentum, conserving its blood supply, and stitches the omentum *via* the pouch of Douglas, over the fistula.

These methods have two factors in common, viz.: (1) closing the fistula, and (2) attempting to increase the blood supply to the operative site. If these requirements are fulfilled, the wound, generally speaking, will heal.

Ureteric transplantation is entirely reserved for the absolutely hopeless case with good anal sphincteric control. It was not undertaken in any of the patients seen by me. Two patients, however, each had a huge immobile fistula with no urethra or perineum. One

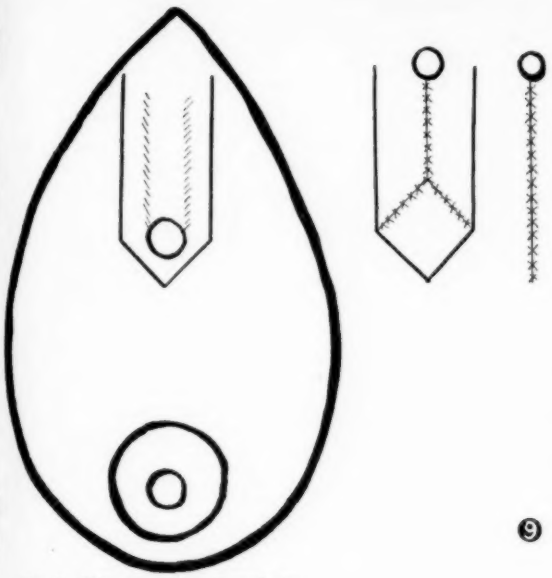


Fig. 9. Diagram of urethroplasty.

had an osteitis of the pubic bone as well. Both these patients underwent some major attempts at closure without success. Finally ileal bladders were constructed in each case, and the women both stated, on their discharge to South West Africa and the Transkei respectively, that they were more comfortable with their colostomies and ileal bladders than with the cloacae inherited from obstructed labours.

of the outer sides of the incised mucous membrane are now approximated, thus completing the new urethra.

In every case, at the completion of the operation, the bladder is washed clear of blood and clots. The surgeon may use any type of needle, instrument or catgut that he finds most convenient for his particular needs. At no time in this series were any instruments used other than the usual scalpel, scissors, needle-holder, catgut, etc. Unless inadvertently done, the mucous membrane of the bladder was never incorporated in a stitch, since this might lead to seepage and a breakdown of an area in the wound.

Post-operative Treatment

Post-operatively, the emphasis is on preventing interference with the blood supply to the wound. Towards this ideal efforts are made by preventing infection; suitable antibiotics are administered. Urinary distension of the bladder is avoided; the indwelling catheter is washed clear 8-hourly in order to prevent blockage. This catheter is removed on the 12th day, and thereafter the patient is made to void urine 3-hourly for 3 days and 4-hourly for a further 4 days. She is told not to allow her bladder to become full for at least 2-3 months and that intercourse is to be avoided at all costs for 3 months. Should she become pregnant, her doctor must be informed that she had a vesico-vaginal repair.

Results

Table II shows the results in the series of 57 operations for urethro-vaginal and vesico-vaginal fistula carried out in accordance with the principles set out above. There were 7 failures in the 57 cases. The failures may be listed as follows:

TABLE II

Race	*Post-operative*		*Following Labour*		*Inflammatory*		*Total*	
	Cure	*Failure*	*Cure*	*Failure*	*Cure*	*Failure*	*Cure*	*Failure*
White	4	1	2	—	—	—	6	1
Coloured	6	1	17	2	2+1*	—	26	3
Bantu	—	—	17	3	1	—	18	3
All Races	10	2	36	5	3+1*	—	50	7
Total	12		41		4		57	

* Sloughing of urethra following the application of an 'ointment' given her by a 'friend'.

In all cases a suitable catheter is stitched into the urethra post-operatively. This is connected to a low-pressure continuous suction apparatus. Thought must be exercised and the type of catheter which might produce tension on the wound is not used.

If the urethra is damaged in addition to the bladder base, or if the injury is primarily urethral, the urethroplasty demonstrated in Fig. 9 is performed, either as an extension of the repair of the fistula, or alone. Two parallel incisions are made through the mucous membrane. The edges are freed and sutured over an indwelling catheter. Whatever muscular and fibrous tissue can be collected on either side is approximated centrally over the newly created canal. The raw edges

White (1), following upon a posterior exenteration. The bladder was found to be densely adherent to the sacrum. The presence of a persistent, non-responding proteus infection and the patient's death 15 months after the operation made a further attempt at repair of this fistula impossible.

Coloured (3). Complicated labour was responsible for 2 of these cases. One patient left hospital with an ileal bladder and colostomy. Her cloaca could not be repaired. One attempt only was made in the other patient; she did not return to hospital for a further operation. It was a small fistula and should have healed after the first attempt. The 3rd patient was 82 years old. She had a sarcoma of the uterus removed

and sustained a bladder injury during the operation. The repaired fistula did not hold, and the patient has since died without a further attempt having been made to cure the fistula.

Bantu (3). One of these cases was cured but broke down 1 month after her discharge from hospital—probably owing to intercourse as she was admitted having aborted incompletely 3 months after discharge. In another patient the first attempt was unsuccessful. It is a fistula which should be closed relatively easily. She, however, has failed to report back. The last patient has been referred to above; she has a cloaca together with an osteitis of the pubic bone, and left hospital with a colostomy and ileal bladder.

CONCLUSION

Since the appearance of a report of a William Meredith Fletcher Shaw lecture delivered by Mahfouz,[5] the full text is awaited with interest. This great gynaecologist has repaired 968 vesico-vaginal fistulae. His last 300 cases were all successful. Excellent results are reported by Charlewood,[1] Lavery,[3] Miller[6] and Moir.[7] In most cases the operation is straightforward and therefore it is unnecessary to resort to transplanting ureters into the rectum unless the patient has been given a full chance of having function restored to an organ which in most instances can be made to function normally. No stone should be left unturned in attempting to cure vesico-vaginal fistulae. There are few patients on this earth who are more relieved mentally and physically than those suffering from this preventable and distressing defect.

That these patients in our unit have done exceptionally well is in no small measure due to the first-rate attention given to them by the nursing staff, house surgeons and registrars.

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'PACATAL'—A CLINICAL TRIAL OF A NEW ATARACTIC DRUG

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The pharmacological control of emotional disorders and psychiatric conditions has become prominent in recent years. Few workers would consider such control in itself sufficient; indeed it is difficult to arrange matters, even with the 'double blind control' in which neither physician nor patient is aware of what tablet is being given, so that suggestion is completely excluded, for the mere giving of a placebo will make some impression on the patient. In the small series described below psychotherapy was given to each patient as was considered most fitting; no attempt has been made at rigid scientific control but the venture has been approached as a clinical trial, with as open and unbiased a mind as possible, against the background of fairly extensive use of chlorpromazine in an analagous group of patients seen in private practice.

The drugs commonly used as pharmacological aids in the various disorders which are by general acceptance termed 'functional' may be divided under several headings:

(*a*) The sedatives, which act largely on the cerebral cortex, and of which barbiturates represent by far the largest group;

(*b*) The stimulants, of which the amphetamine group, caffeine and some phenyliso-propylamine derivates such as Ritalin are representative;

(*c*) the hormones, such as thyroid, oestrogens, androgens and various steroid derivatives;

(*d*) relaxants of the dioxolane group, such as dimethylane and mephenesinium, which act by inter-neuronal blocking effects;

(*e*) abreactives, such as CO_2 used in inhalation therapy and acetylcholine used intravenously;

(*f*) the hallucinogens. of which lysergic acid is the most commonly used;

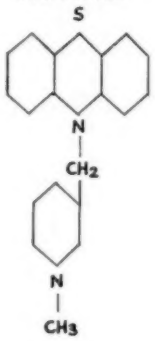
(*g*) sympathetic inhibitors such as reserpine; and

(*h*) the anticholinesterase drugs, such as chlorpromazine and the antihistamines.

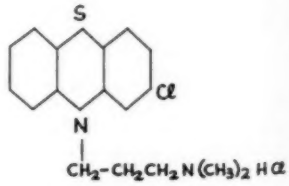
This list could be further enlarged and its subdivisions are by no means mutually exclusive as chlorpromazine as well as being an anticholonesterase has a sympathicolytic effect, but it is given to remind one of the complexity of the question of pharmacological control of the psyche.

Pacatal is a phenothiazine derivative with the formula:
N-methyl piperidyl-3-methyl phenothiazine

PACATAL



CHLORPROMAZINE



Owing to its heterocyclic chain structure it differs chemically from chlorpromazine. The two graphic formulae are as follows:

Pacatal has a relatively low toxicity and has been given continuously to dogs for 2 months, without any untoward effects, in doses of 10-20 mg. per Kg bodyweight, orally. It appears to have some depressant effect on the parasympathetic nervous system since it blocks the action of pilocarpine on salivary flow in rabbits and inhibits secretions in rats.[1] Its mydriatic activity is slight but it has a distinct drying effect on the upper respiratory passages.[2]

On the sympathetic system Pacatal has a depressant effect; it causes inhibition of contraction of the nictitating membrane. The cartoid-sinus reflex and pressor reflexes were inhibited but noradrenaline was not blocked. In normal individuals 50 mg. of Pacatal given intravenously was found to lower the blood sugar slightly.[3]

Pacatal, like chlorpromazine, potentiates the analgesic properties of morphine and phenacetin and reduces the reaction to pain by both a peripheral and central action.[4]

Pacatal has not the same effect as chlorpromazine on the circulatory system, because it does not lower the blood pressure or affect the pulse rate.[3]

In estimating the qualities of any drug clinically, the venue for the trial must be carefully chosen so as to show up the qualities of the drug most advantageously as well as define its limitations. It is obviously wrong to estimate the effect of a drug solely suitable for the sedation of mildly agitated persons by trying it only against wildly maniacal psychotics; a negative finding will be arrived at (that the drug is useless in mania) but no positive affirmation can be made. The negative discovery is of course of some value in defining the boundaries of future trials but it is not sufficient in itself.

In the following summary of a recent trial of Pacatal, 2 main groups of patients were used: (*a*) Ambulatory persons who were going about their daily tasks but who found certain difficulties such as tension, lassitude, insomnia and depression, interrupting their usual efficiency, and (*b*) patients who had been so severely affected as to warrant nursing-home treatment. There were no cases of the certifiable class. Amongst those who were receiving nursing-home care a further division could be made into those receiving some form of electroconvulsive or electronarcotic therapy and those who were not receiving this therapy.

Dosage. Pacatal was supplied in 50 mg. tablets and in ampoules of 50 mg. in 2 c.c. solution.

In most of the nursing-home group an initial deep intramuscular injection of 75 mg. was given followed by 100-200 mg. by mouth.

With ambulatory patients 50 mg. was given *t.d.s.*, or if the problem was mainly one of poor sleep an initial 100 mg. of the drug was given ½ hour before retiring. In a few cases the dosage was raised to 100 mg. *t.d.s.* With those who were treated in bed an initial dose of 75-100 mg. was given intramuscularly.

It was found that by diluting this dose with sterile water to 10 c.c. the pain of the injection was reduced. At first deep muscular injections were not given and most of the patients complained of severe pain; local anaesthetics such as 2% procaine were not found to be satisfactory in overcoming this pain, and when the anaesthetic effect wore off the patient continued to complain of pain for a further 24-48 hours. Later the injections were given deeply into the buttock muscles and this was found to be much less painful. Hyaluronidase was given with some of the intramuscular injections but apart from appearing to hasten the calming effect of Pacatal it did not seem to have any other effect and the injection site remained tender.

In the very excited, agitated and hypomanic cases the dosage required was very variable, and although 800 mg. a day in divided doses was usually sufficient to induce calm sleep, there were cases where this dosage was quite inadequate.

Finally, except in the ambulant cases, Pacatal alone was not usually sufficient to quiet the patient and the drug had to be used in combination with a barbiturate. A very satisfactory method of inducing therapeutic sleep for a week or 10 days was found by combining 200 mg. of Pacatal with 400 mg. of Noludar (Roche), i.e. 2 tablets of the latter drug every 6 hours. As some patients object to taking large numbers of tablets the Pacatal and Noludar were often crushed and given together as a powder to be swallowed with water.

SIDE-EFFECTS

Dryness of the mouth and a loss of taste was a frequent complaint of patients taking Pacatal. A few complained of blurring of vision and in those having high dosages dizziness and actual ataxia occurred. Many patients remarked on their vivid dreams while taking the drug, an effect which is shared with chlorpromazine.

There were no cases of jaundice or blood dyscrasia.

Of the 53 patients under treatment with Pacatal, 3 developed nausea and 1 vomited after being given the drug. Anorexia might be a side-effect in about a quarter of the patients, but this was difficult to estimate because in many patients anorexia was part of the symptom-complex which led them to consult their doctors.

Despite the experimental evidence that Pacatal had little anticonvulsant effect,[1] clinically in giving electroconvulsive treatment to patients it was found to have a very marked anticonvulsant effect. This is a drawback in electroconvulsion therapy since, if a convulsion is not produced, the patient is often confused for a considerable time after the treatment. It must, however, be remembered that part of this anticonvulsant effect is due to the potentiating effect of Pacatal on barbiturates and Noludar. It was noticed that intramuscular Pacatal alone had no adverse effect on electrocoma treatment, where a convulsion is not aimed at, and indeed it seemed to help considerably in this treatment, for patients who tended to wake up 2-3 minutes after the commencement of treatment were found to take the full 10-15 minutes of passage of electric current without waking after administration of the drug in its usual daily dosage.

CASE RECORDS

In starting trials with a new drug there are bound to be failures for two main reasons, firstly because the

medicament is used on unsuitable cases, and secondly because inadequate dosage or too high a dosage is used. Only by trial and error can an estimate be arrived at, and the over-all clinical impression at the end of the trial is probably of more importance than any study of statistical effects. The reader is therefore referred to the concluding remarks of this article before judging from the following figures.

Furthermore Pacatal alone in a few of the more severely affected cases was not sufficient, but by its potentiating effects it was most useful in cutting down the amount of barbiturates or other drugs given.

The following tabulation shows the satisfactory as compared wiht the unsatisfactory responses. The latter group include those in which the drug was abandoned either because it was ineffective or because of the resulting anorexia or nausea or dryness of the mouth.

	Satisfactory	*Unsatisfactory*
Ambulatory Patients		
Agitated depressions and tension states ..	8	2
Simple depression (reactive or cyclothymic)	1	4
Migraine and a typical facial neuralgia ..	5	2
	14	8
Nursing Home Patients		
Agitated depressions and tension states:		
with electrotherapy	10	2
without electrotherapy	6	2
Hypomania—with electrotherapy	2	0
Drug withdrawal	2	1
Alcohol withdrawal	6	0
	26	5

The patients who were depressed without a great deal of tension were those who did least satisfactorily on Pacatal. As with chlorpromazine the best results were those who were agitated, restless, sleepless and tense.

A few illustrative case notes may be of help in estimating the effects of Pacatal:

Case 1. H.W., a journalist 48 years of age, had for the last 3 years found himself becoming increasingly tense and sleepless. He had had a considerable amount of domestic anxiety and his work was unsatisfactory and frustrating. He had a typical tension-reaction to all this background of real worry and he found he could not concentrate or settle to anything and his sleep was broken and unrefreshing. He was a man of high intelligence and initiative and had no previous breakdown; he still did his work but he felt as if 'something would happen' if he did not achieve sleep and relaxation; amphetamine, various sedatives, a sea-trip and advice from a number of physicians had all been without avail.

After a preliminary psychotherapeutic interview and survey he was put on to Pacatal, 50 mg. *t.d.s.*, and when seen a week later he was much better. He felt less tense and, although he took nothing else to induce sleep at night, he slept well. He has been seen at weekly intervals for 6 weeks and has remained well. His impression is that Pacatal does not make him feel lethargic in any way during the day but helps him to sleep at night by giving him what he calls a 'more relaxed platform' to start off the night.

Case 2. A.P., a physician 49 years of age. For 7 years he had been taking drugs—omnopon, pethidine and large amounts of barbiturates. He was desperately trying to stop the drugs but when seen was in a state of great depression and agitation. He would pace up and down his room wringing his hands, clutching his head and appealing for help from his inner restless torment.

He was taken into a nursing home and given 75 mg. of Pacatal *i.m.* and put on 200 mg. *t.d.s.* He immediately became quieter and less agitated and slept for 14-18 hours a day with the aid of paraldehyde, 10 ml. by mouth twice daily.

A week later he began to complain of a restlessness in his legs, the 'jittery legs' of Ekbom, which did not respond to increased doses of Pacatal or chlorpromazine, but which responded temporarily to reserpine.

Comment. Both these patients were intelligent men trained, in different ways, to observe reactions. Both were quite certain that Pacatal was effective where other sedatives of the barbiturate, bromide and hyoscine groups had been ineffectual. In the doctor patient Pacatal failed to relieve the supervening intensely felt feeling of restlessness in the limbs although it calmed him inwardly in a satisfactory manner. In the first case, by dissolving the bands of his tension, it allowed the patient to continue at his work with better concentration and more zest than previously, and in the second case it produced calm sleep with quite small doses of paraldehyde in a man accustomed to taking big doses of various drugs.

Case 3. L.M., a European housewife aged 35 years, with occipital headache, frontal and periorbital pain, usually on the right side but sometimes on both sides. These headaches had been present for some years and were often precipitated by fatigue or emotional upset, but latterly had tended to become more and more frequent and to last up to a week at a time. The usual remedies for migraine had failed to help them and they were undoubtedly of that class of headache called 'muscle-contraction headache' by Tunis and Wolff.[5] On Pacatal, 50 mg. *t.d.s.* and 100 mg. at the very onset of a headache, she was much improved. Although she usually lay down for an hour or so after the 100 mg. dose she would avert the headache, which previously would have incapacitated her for at least a day.

Comment. The muscle-contraction type of headache is a common cause of distress and partial incapacitation amongst people of all classes, but particularly in the housewife in her thirties and forties with the usual press of duties and responsibilities and the stress of modern living. Psychotherapy certainly plays a major part in the resolution of this kind of headache, together with rearrangement of the living-pattern into a less stressful form, but what the patient usually craves for is something to take which will give an immediate relief from symptoms. Pacatal in the dosage given above, has been of great help in this kind of case.

Case 4. P.B. aged 40, a chemist by trade, had been undergoing a considerable amount of stress relating to a business partnership and building undertakings. He had always been a very quiet man, perfectly self-contained, but rather suspicious. For a week before being first seen he had been restless, talkative, and mildly elated. The day before he was seen his elation and activity increased, and when seen he was in a typical hypomaniac state with a great pressure of talk, flights of ideas, and moods which swung from an all-embracing euphoria to swift and angry aggressiveness. He knew a good deal about the effect of drugs and refused to take barbiturates in any form 'because of the danger of suicide' and refused to have chlorpromazine 'because it causes jaundice'. He was eventually persuaded to take Pacatal, 200 mg., and Noludar, 400 mg., crushed up together and was kept on this dosage 3 or 4 times daily for 10 days, during which time he had electroconvulsive therapy. He made a full and surprisingly uneventful recovery except for the 4th day of treatment, when he refused all drugs by mouth and became very elated and aggressive and had to be given 100 mg. of Pacatal by injection.

Comment. This case raised some extraneous difficulties in that the patient refused to have either barbi-

turates or chlorpromazine. Nevertheless Pacatal proved itself an excellent substitute and indeed, along with Noludar, it is difficult to see how the case could have been better controlled. It should be made clear that the Pacatal merely facilitated nursing and the giving of the electroconvulsive therapy—it was the latter which improved his hypomania—but without Pacatal the management of the case and the rapid recovery could not have been achieved.

CONCLUSIONS

Pacatal compares favourably with chlorpromazine in the control of a group of cases with emotional disorders, tension states, and muscle-contraction headaches. It is not in itself a nostrum but it does help the physician in the management of the patient and it helps the patient by lessening his inner tension. Nearly all those who took Pacatal said they felt calmer and slept more readily. The side-effects as compared with those of chlorpromazine are few—no rashes, no jaundice, no blood dyscrasia, no marked alteration of blood pressure or pulse rate. It did, however, produce a dryness of the mouth which was unpleasant in some cases; blurred vision, anorexia and, in big doses, ataxia were also produced, but it should be noted that the bigger doses were usually employed only in the most severely agitated cases and the side-effects were mild compared with the increased control of agitation and tension.

As with chlorpromazine, the dosage required for individual patients may vary from 100 mg. in one to 800 mg. in another, though they may be clinically comparable. In our experience, Pacatal proved somewhat more painful than chlorpromazine on injection, but by means of dilution with water and deep injection this can be ameliorated.

In using Pacatal one must remember its potentiating effects, which are like those of chlorpromazine, on hypnotics and analgesics. In electroconvulsion therapy Pacatal seems to have an anticonvulsant effect which may make the treatment more difficult, but in electric-coma treatment it helps, probably by potentiating the effect of the introductory intravenous thiopentone, in keeping the patient asleep while the current is being passed.

SUMMARY

Pacatal, a phenothiazine derivative, is structurally related to chlorpromazine but differs in its heterocyclic side-chain structure. Indications for its use are similar to those for chlorpromazine but it has less side-effects.

There is a very definite place for the use of Pacatal and some indications for its use are discussed.

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THE MENACE OF TUBERCULOSIS AND THE DANGER OF SANTA

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The first part of the above heading needs no explanation, extension or argument for any medical people whose work brings them into direct contact with this disease, especially as it occurs amongst the Bantu. But even for some of them, and certainly for the many medical practitioners in the multitude of diverse specialties and occupations contained in Medicine today who are not immediately concerned with the ravages of this particular disease, the second part of the heading certainly calls for some sort of explanation and justification. It is my purpose to endeavour to supply both: not because I wish to attack SANTA (the South African National Tuberculosis Association) as such, but because I feel strongly that the presence of SANTA in our midst is (unwittingly) blinding the eyes of Government and public alike to the vastness of this whole problem. And when I say Government I am not referring specially to the present Government, but to any Government. There is nothing political in this, because this is a matter altogether beyond party-politics: and there is nothing personal in it, except that, as a person who has been engaged for nearly 30 years in working with and for sick Bantu, I have some small claim to know what I am writing about.

The immensity of the problem of tuberculosis as it occurs in the Bantu has been ever before me for many years; and I have tried without success during the past few years to get, through the Union Department of Health, an adequate grant to enable us to build a separate tuberculosis hospital here to accommodate the ever-increasing number of patients suffering from open pulmonary tuberculosis who come seeking admission. But always we have come up against the stone wall erected, unwittingly no doubt, by SANTA in their provision of *settlement beds* at a cost not exceeding £150 per bed—a price at which it is impossible to build and equip a *hospital*. In the end our Hospital Board decided to drop the whole project. But when, at a recent count, I found that in this general hospital of 130 beds we have no fewer than 90 patients suffering from tuberculosis. I realized that whether we were disgusted or not, whether we wanted to do so or not, we were *compelled* to reopen the campaign for the provision of more accommodation, not only here but throughout the country.

And then—I happened to read the editorial in *The Territorial News*, Umtata of 20 September:

'The eighth annual meeting of delegates from the many branches of SANTA was held in Port Elizabeth last week. Since its inception, this splendid body has gone steadily forward in its aim to halt the spread of the dread disease which, it was at one time feared, would play such havoc with the Union's indigenous population that their future would be gravely imperilled. Thanks to scientific discoveries in recent years, and to a more vivid realization of the danger ahead, hope has been aroused that, within a measured term of years, tuberculosis can be overcome, provided the public generally remains conscious of the danger, and is prepared to assist in its eradication. The first and most important steps necessary to fight the spread of the disease is the segregation of the sufferer in a manner which will prevent its communication to others.

'The heavy cost of building hospitals makes it impracticable to provide hospital beds for all those requiring treatment, and it is in this direction that SANTA has come to the aid of South Africa. Instead of £1,500 required for each hospital bed, SANTA has found the way to provide beds at an average cost of a little

over £100. In the past 8 years SANTA has made 1,970 beds available, and expects to add another 700 to this total before the end of March next. Each year will produce the maximum number which available funds can finance, until such time as the backlog in beddage has been overtaken. When it is borne in mind that the administration of all the settlements established has been almost entirely in the hands of local voluntary workers, the results achieved are indeed worthy of note. In addition to caring for the sufferers themselves, SANTA has done and is doing good work in caring for dependents, so that the patients are relieved of a good deal of worry which, otherwise, might hinder recovery.

'Among the additional settlements contemplated for the present financial year is one at Umtata, which it is hoped to see started within a very short time. Consideration is also being given to a number of settlements within the Reserves, though nothing definite has as yet been decided in this connection.'

Now *The Territorial News* is the leading paper in the Transkei, and the Transkei is the biggest Native Reserve in the whole Union. The Editor of this paper has published this article in all good faith: and it is not beyond the bounds of possibility that editors of papers with a wider circulation might very well publish articles of a similar nature. And what is the harm, or danger?

In the first place it seems to me that the general impression conveyed to the minds of the public might be that with the 'wonder drugs' now in medical hands for combating this disease, allied to the efforts of SANTA, the problem and the dangers of tuberculosis are neither of them so great or so serious after all; and that if we only had more SANTA settlements the whole thing could be brought under reasonable control in a comparatively short time. This, unfortunately, is far from being the truth.

The second paragraph of the article gives an entirely wrong impression. SANTA does *not* provide hospital beds because SANTA does *not* provide hospitals. What SANTA has undertaken to do is to endeavour to provide settlements or colonies where the fortunate few—patients who have been in hospital for a considerable time and who are now convalescent or in those whom the disease is already quiescent—can carry on their treatment with or without their families beside them. In any case the settlement idea postulates patients who are ambulant, i.e. who are able to be up and about for most of the day and who are even able to undertake light tasks.

This however takes no cognisance of the vast majority of Bantu sufferers from tuberculosis who are *quite unsuitable for admission to SANTA settlements* and whose primary need, and indeed whose *only hope* is to be accommodated in proper hospital beds where they will have to remain strictly in bed for varying but lengthy periods of time. Now, there is a great difference in the cost of building a *hospital* in the true sense of the word and building a SANTA settlement.

The Editor is not exaggerating when he quotes the figure of £1,500 per bed as being the cost of building and equipping certain hospitals for the treatment of tuberculosis. The Government has in recent years constructed hospitals at this very high cost; but also in recent years when mission hospitals, such as our own, have gone forward to the Government with offers to build hospitals and provide beds for the treatment of tuberculosis at a very much lower figure, provided the Government will make adequate grants, these have been turned down and we have been told in effect that if SANTA can provide beds not costing more than £150 then we should be able to do the same. It is perfectly amazing that high officialdom should have been misled into this same confusion of thought in comparing the cost of providing beds in *hospitals* with that of beds in a *settlement* or *colony*; but that is what has happened.

In our case we offered to build and equip a 100-bed hospital here at Sulenkama at a cost of only £300 per bed, which is one-fifth of the cost incurred in certain Government Institutions. Not only so, but we are able to run our mission hospitals—and run them well—at a cost per patient-day of anything from a half to a forth of the costs pertaining in Government hospitals. But I repeat, our offer has been turned down because the Government (with no excuse) has made the same mistake of confusing proper hospital beds with SANTA beds.

It would be well to face the truth, and one aspect of the truth is contained in the report of part of a speech made by Dr. M. J. Broderick, National Secretary for SANTA as reported in the *Sunday Times* for 22 July 1956, and which reads as follows:

'HOME TREATMENT OF T.B. HAS FAILED IN S. AFRICA. MORE BEDS NEEDED IN HOSPITALS'

'Contrary to what was thought a year ago, the experiment of home treatment of tubercular patients, particularly non-Europeans, is not a success, and has not provided an answer to a tremendous problem.

'Tuberculosis was gaining ground in South Africa in spite of all efforts to combat it, said Dr. M. J. Broderick, National Secretary of SANTA, when he spoke at a conference of the South-Western Districts Regional Santa Committee at Mossel Bay.

'One of the first things in home type of treatment was to educate the patients about the spread of infection, he said.

'How could the spread of disease be prevented when patients receiving treatment in their homes, were ignorant of the ways and means in which the disease spreads?

'Drugs do not cure—they only help the body overcome the disease, said Mr. Broderick.

'What is needed is more hospital accommodation where patients can be properly fed and rested. More beds, in short, are required.'

Another aspect of the truth is contained in the figures arrived at by a leading Tuberculosis Officer in Government employment who, as the result of a survey and investigation carried out in the Transkei, arrived at the conclusion that, on a conservative estimate, 2·3% of the Native population of the Transkei is suffering from active open tuberculosis, i.e. the type requiring hospital beds.' Now this would work out at the shattering figure of over 30,000 individuals *in the Transkei alone* . . . suffering from active tuberculosis.

When we revert to the above editorial we read: 'In the past 8 years SANTA has made 1,970 beds available and expects to add another 700 to this total before the end of March next'.

Let us then add these two figures together and say that by the end of March next SANTA hopes to have made available 2,670 beds, and let us remember that these beds are for the convalescent and/or ambulant type of patient. Now set this figure of 2,670 against the figure quoted above of 30,000 and let us remember that 30,000 represents the estimated figure for the Transkei only, and it immediately becomes apparent that despite their splendid efforts SANTA is barely touching the fringe of this mighty problem, and indeed these very same efforts are in danger of lulling the public mind into a state of complacency over what is indeed the greatest public health menace in South Africa.

Further on the article says, 'Each year will produce the maximum number (of beds) which available funds can finance, *until such time as the backlog in beddage has been overtaken*'.

Until such time! When is this state of Utopia to be reached? If it has taken SANTA, with all the help of voluntary workers and newspaper publicity and all the rest of it 8 years to provide 2,000 beds, it is obviously utterly impossible for them to overtake this problem in any measurable or practical period of time.

By all means let us pay tribute to the splendid efforts of the voluntary workers and paid officials of SANTA and let us go on supporting them to the limit of our ability. But this problem goes far beyond SANTA or any other private organization and *can only be dealt with at top level* by the Government working through the Union Health Department, the Provincial Administrations and possibly the Native Affairs Department.

This is probably the most real of all the 'problems' in our country today: and only a Government can command the necessary funds to tackle it. Money will have to be spent, plenty of money: but a tremendous economy could be effected if the Government would avail itself of the many mission hospitals throughout South Africa which are able, for a variety of reasons, both to build and to run at much lower costs than the Government can be expected to achieve through its usual channels.

SUMMARY

It is submitted:

1. That SANTA is (unwittingly) blinding the eyes of Government and public to the immensity of the problems of tuberculosis.

2. That because of the low cost structure of providing beds in SANTA *settlements*, mission hospitals are being offered inadequate grants for the building of *hospitals* for the treatment of tuberculosis.

3. That there is a danger of the public being misled into a state of benevolent complacency as the result of newspaper articles

written in all good faith but based on misconception and on lack of knowledge of the true facts.

4. That the incidence of active, open tuberculosis in the Native population is truly appaling; and that it constitutes a problem which *cannot* be tackled by any 'private' organization but must be dealt with at top level by Government.

5. That if it only would, the Government could work through the many valuable mission hospitals in the Union and so provide more hospital beds for tubercular patients at an economical figure.

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ANNUAL REPORT OF CHAIRMAN OF RMO GROUP FOR YEAR ENDING 30 SEPTEMBER 1956

L. O. VERCUEIL

The results of our negotiations with the Executive Committee of the Central Sick Fund Board have been circulated to all members of the Group.

The increase of 3s. 0d. in basic capitation rate for general practitioners is substantial, and will amount to over £50,000 per year. Although many RMOs will receive the 20 shillings capitation rate we requested for everybody, there are still many who will not. The Sick Fund is adamant on the point that there should be a difference between the capitation of the RMO undertaking surgery, and the one who does not. Surgical work has been done by specialists only for so many years in the large centres in the Union that one cannot blame lay people for thinking that the man who does surgery has greater 'magic' than the one who does not.

Perhaps in time the Sick Fund will do what the Mines Benefit Society and other big benefit societies do, viz., pay a uniform capitation rate. The reason why several of the requests were turned down was merely SAR policy, and because they would have resulted in more favoured treatment for RMOs than other railway servants if they had been granted. This applies to the request for RMOs to become members of the Sick Fund, and the request for a limited number of PTOs for retired RMOs.

On the whole our negotiations have been successful in getting a capitation rate nearer to that laid down by the Medical Association.

Increased Fees for Paediatricians. I anticipate that the pre-membership fee will be raised. The Sick Fund is awaiting the report of Mr. Hurley in this matter.

Physical Medicine Specialists. As the result of our request for the appointment of physical medicine specialists a pilot scheme will be tried out in the Western Transvaal system. The posts will be advertized in the near future.

Swart Scheme. The Swart Scheme is being implemented in the Transvaal, and I call on all RMOs affected to cooperate and make it a success. There may be numerous little difficulties at the beginning, but they will be surmounted. As regards the grouping of the various districts, the District Boards have shown a desire to meet the wishes of the RMOs, and the latter were all consulted. To the additional RMOs who have been appointed, we extend a hearty welcome and hope they will join our Group. It may take anything from 1 to 3 years to extend the scheme to the other provinces. I hope that a friendly spirit of competition and co-operation will prevail. It is hoped that the RMOs will not pander to patients in order to increase the size of their panels. Very often with limited open panels there is a tendency for medical practitioners to be liberal in their prescribing and a tendency to meet 'request' medicines, which are sometimes of a most expensive nature. The too easy issuing of sick notes to draw 'custom' may also cause a rise in the already scandalous amount paid out in in sick-pay by the Administration. We must assist the Administration in keeping the wheels turning.

Cost of Medicines—Drugs and Dressings. This year the cost has not shown the same fantastic rise as in previous years, although it has increased, and I still feel that there is room for further reduction in the cost structure. Some RMOs are still prone to prescribe expensive antibiotics and other medicines and drugs, where much cheaper preparations would be equally effective.

Sick-pay. The amount paid out by the Administration is far too high; in fact it amounts to nearly 6 times more per member per month than in the Mines Benefit Society. This is certainly not to the credit of the RMOs, who should clamp down on malingering and on undue liberality in issuing sick certificates.

Boycotting of Specialist Posts. The boycotting of urological and orthopaedic posts was to my mind quite unnecessary, for the salaries advertised were adequate as far as we can judge at this stage. Many of the RMOs and salaried specialists took an active part in the negotiations which resulted in the calling off of the boycott. If the RMO Group approves of the salaries attached to posts, it should be an indication to the rest of the profession that these posts are in order.

Membership of Group. It should be our endeavour to get a 100% membership of our Group. With the appointment of additional specialists this year, our Group, the oldest in the Medical Association of South Africa, is probably numerically the most powerful in the Association.

Resolutions passed at Federal Council at Vereeniging, April 1956

The following resolution was passed by Federal Council and was carried by 35 to 4 votes, and I requested that my vote be recorded against it.

Branch Contract Practice Committees: 'That Branches shall manage all Contract Practice affairs in their areas, including Medical Aid Societies, Medical Benefit Societies, Railway appointments and all other affairs which may be referred to them by Federal Council as being matters of "Contract Practice"'.

This amazing resolution takes away our right to negotiate direct with the Sick Fund, which I strongly resent.

In 1949 the RMO Group requested the Medical Association to negotiate with the Sick Fund on their behalf. For a year nothing happened because the Sick Fund refused to negotiate with anybody but the RMO Group. Eventually the RMO Group requested Federal Council to be allowed to negotiate again on its own behalf. The result you all know, and there has been a considerable improvement in our conditions of service, which was due to our own efforts, although we were appreciative of the value of the solid backing of the Federal Council and the Association. Unfortunately there are quite a number of Federal Council members who have not the foggiest notion of Contract Practice and the difficulties of benefit societies, and allow themselves to be swayed by some 'extremists' north of the Vaal. Unfortunately there are now some 'extremists' in the Cape also.

We are well able to manage our own affairs and strongly resent any interference between us and the Sick Fund. It may destroy the cordial relationship that has been built up between the RMO Group and Sick Fund over the last 7 years.

Your executive passed the following resolution which will be debated at the Federal Council Meeting in Cape Town in October: 'The RMO Group requests that the *status quo ante* be restored as far as the RMO Group is concerned, because this group is not sectional, nor does it represent the interest of any individual section of the profession'. If we require the assistance of the Association, we shall ask for it, but we resent meddlesome interference.

Closed and Open Panels. The following resolution was also passed by Federal Council:

'That the policy of this Association shall be to ensure free choice of doctor by the patient, and of patient by the doctor. In pursuance of this policy all future appointments to Benefit Societies should be on the basis of open panels for general practitioners and specialists, unless in exceptional circumstances and after approval by Federal Council.'

A motion will be put forward at the October meeting of Federal Council for the recission of the above resolution. We all know that an open panel is the ideal set-up, but it is entirely impracticable as far as the Sick Fund is concerned. Specialists' fees at Medical Aid rates would break the Sick Fund in less than a year. Federal Council members are apt to forget that the average incomes of railway employees are low, and that the Sick Fund conforms to the Association's requirements for a benefit society

in every respect. The Mines Benefit Society at its inception tried an open panel for specialists, and nearly went bankrupt within 6 months. The present system of salaried specialists for the Sick Fund has answered extremely well and some of the ablest specialists in the Union now serve the Sick Fund.

If we have to fight the Medical Association on these two issues, it will just be too bad. We are a powerful group and we should not shirk the issue.

Unnecessary Consultations and Visits. There is no doubt that a substantial number of beneficiaries abuse their privileges. Night visits for the most trivial ailments are extremely common, especially in certain parts of the Reef. A certain proportion of such calls may arise because the mother is working and comes home and finds her child ill, but the majority of them are due to a minority of beneficiaries who habitually send at night because they think they have bought us body and soul. The Sick Fund should assist us in this matter. Our request for a levy on medicines to prevent excessive visits and consultations was turned down. It is for the Sick Fund to devise means through Staff Publications to assist us.

Libellous Statements about RMOs to District Boards by Members of Sick Funds. I should like the General Meeting of the Group to debate this matter and decide on action. There is no doubt that very often members in attempting to obtain refunds from the Sick Fund for services rendered by private practitioners make false and libellous statements about RMOs.

Overburdening of Specialists

There are a number of RMOs, especially in the big cities, who refer the most trivial cases to specialists, either through a desire to get rid of the patient or to pander to the wishes of the specialist-conscious patient.

The 3 physicians in Johannesburg are now doing as much work each as when there was only one appointee. A certain ophthalmologist in a big city told me that sometimes 20 cases of foreign bodies in the eyes are referred to him in one day, without the RMOs having made the slightest attempt at removal. RMOs should make the preliminary investigations themselves before reference to specialists.

Specialists should act as consultants only, and RMOs should attend their own cases in hospitals and nursing homes where distances permit. If we do not do that we shall sink to the level of the general practitioners under the State medical scheme in England, where it is bad for the general practitioner to lose his stethoscope, but a catastrophe if he loses his pen.

Reluctance to apply for General-Practitioner RMO Posts. With so many posts vacant in the past few months through the Swart scheme, it was again noticeable that even with the increased capitation rate many excellent practitioners were unwilling to apply for these posts. The answer when I suggested they should apply was, 'Railway patients are far too exacting and cause far more work than people of other benefit societies, and I do not want to ruin my private practice'. They also resented the amount of correspondence.

Consulting and Waiting Rooms. From time to time complaints are received that the consulting rooms of some RMOs—general practitioners and specialists—are not neat and clean and are unsuitable. One of the highest-paid specialists of the Sick Fund uses consulting rooms, which, up to recently anyway, were very shabby. This state of affairs can of course not be tolerated.

Liaison Committees of RMOs should be established in every System where they have not been established already. These committees serve a most useful purpose.

Relations with Sick Fund. I do not think the relations between the Group and the Sick Fund have ever been better. The Sick Fund is always prepared to give us a hearing and treats us with courtesy, which is more than I can say of another big benefit society. On our part, I think, we should serve the beneficiaries to the best of our ability, and eventually acquire the same high reputation that the old Indian Medical Service had in India during British rule.

Agenda for Annual General Meeting in October. I am pleased that Branches have not sent requests for further increases in capitation fees and emoluments. I think for the time being constructive items should be put on the agenda, which will be of benefit to the Sick Fund.

Thanks. In conclusion, I wish to thank the members of our Executive for the work they have put in on behalf of the Group, and the members of the Group for support of the Executive. A great deal of the success of our Group is due to our conscientious and able Secretary, Dr. M. Cohen. I think he is the ablest Group Secretary in the Medical Association. As I am Chairman of the Central Committee for Contract Practice and have dealings with all Group Secretaries, I am well able to judge. We, and myself in particular, owe him a great debt of gratitude. He never resents my telephoning him at 6 a.m. to discuss Group matters. I wish to thank you all for my unopposed nomination for the Chairmanship for the ensuing year.

ANNUAL GENERAL MEETING OF RMO GROUP

The Annual General Meeting of the Railway Medical Officers Group was held at Cape Town on 1 October 1956, the Chairman of the Group, Dr. L. O. Vercueil, presiding.

After the Hon. Secretary, Dr. M. Cohen, had read his annual report, the Chairman submitted his annual report, which is published above.

A full discussion took place of the various items of the agenda, and all members of the Group will in due course receive a copy of the minutes.

The following honorary office-bearers of the Group were elected for the ensuing year: *Chairman*—Dr. L. O. Vercueil, P.O. Box 20, Maraisburg; *Vice-Chairman*—Dr. H. Penn, Medical Centre, Jeppe Street, Johannesburg; *Hon. Secretary and Treasurer*—Dr. M. Cohen, 66 Judith Road, Emmarentia, Johannesburg.

THE MEDICAL ASSOCIATION OF SOUTH AFRICA

MINUTES OF A MEETING OF THE FEDERAL COUNCIL HELD IN CAPE TOWN ON 3, 4 AND 5 OCTOBER 1956

Minutes of a Meeting of the Federal Council of the Medical Association of South Africa, Held at Red Cross House, Cape Town, on 3, 4 and 5 October, 1956.

Present:

Ex Officio: Dr. J. S. du Toit (President), Mr. J. D. Joubert (Hon. Treasurer).

Border Branch: Dr. B. Navid, Dr. R. Schaffer.

Cape Eastern Branch: Dr. L. R. L. Solomon.

Cape Midlands Branch: Dr. P. Jabkovitz, Dr. M. A. Robertson.

Cape Western Branch: Mr. J. A. Currie, Dr. J. P. de Villiers, Dr. F. O. Fehrsen, Dr. A. I. Goldberg, Dr. R. Lance Impey, Dr. A. Landau, Dr. J. R. E. Lee, Mr. T. B. McMurray, Mr. J. A. S. Marr, Dr. H. G. Owen-Smith, Dr. F. W. F. Purcell, Dr. A. W. S. Sichel (Chairman of Council).

East Rand Branch: Dr. E. Meltzer, Dr. J. Q. Ochse, Dr. E. W. Turton.

Griqualand West Branch: Mr. N. Kretzmar.

Natal Coastal Branch: Dr. S. Disler, Dr. K. W. Dyer, Dr. H. Grant-Whyte, Dr. N. A. Rossiter.

Natal Inland Branch: Mr. B. A. Armitage, Dr. N. M. Thompson.

Northern Transvaal Branch: Mr. J. G. A. du Toit, Dr. B. Epstein, Dr. J. H. Struthers (Vice-Chairman), Dr. W. Waks, Dr. F. Ziady.

O.F.S. and Basutoland Branch: Dr .D. Serfontein, Dr. R. Theron, Dr. G. F. C. Troskie.

Southern Transvaal Branch: Dr. A. L. Agranat, Dr. J. Black, Dr. W. Chapman, Dr. R. C. de Kock, Mr. G. T. du Toit, Dr. J. Gluckman, Dr. T. Radloff, Dr. Lewis S. Robertson, Dr. M. Shapiro, Dr. L. O. Vercueil, Mr. J. Wolfowitz.

Transkei Branch: Dr. I. R. Ross.

In Attendance: Dr. A. H. Tonkin (Secretary), Dr. L. M. Marchand (Associate Secretary).
Observer: Dr. T. Shadick Higgins (Editor).

WEDNESDAY, 3 OCTOBER

The Chairman, Dr. A. W. S. Sichel, opened the meeting at 10 a.m. and welcomed members.

1. *Notice Convening the Meeting*, published in the *Journal* of 18 August, 1956, was taken as read.

2. *Proxies and Apologies:* The Chairman called for Proxies, and these were read as follows: Dr. Struthers to act for Dr. Sypkens, Dr. Disler to act for Dr. Taylor, Dr. Dyer to act for Dr. Deale, Dr. Rossiter to act for Dr. Broomberg, Dr. Meltzer to act for Dr. Segal, Dr. R. C. de Kock to act for Dr. C. Adler, Mr. Kretzmar to act for Dr. Collins, Dr. Jabkovitz to act for Dr. Lane, Mr. Armitage to act for Dr. Paradisgarten, Dr. B. Navid to act for Dr. L. L. Alexander.

Apologies were noted from Dr. C. Adler, Dr. L. L. Alexander, Dr. A. Broomberg, Dr. L. E. Lane, Dr. M. Peskin, Dr. J. H. Harvey Pirie, Dr. T. Schneider and Mr. J. S. Visser.

3. *Introduction of New Members:* Mr. Armitage introduced Dr. N. M. Thompson, Dr. Agranat introduced Dr. R. C. de Kock, Dr. Struthers introduced Dr. B. Epstein, Dr. Schaffer introduced Dr. B. Navid, Dr. M. A. Robertson introduced Dr. P. Jabkovitz, Dr. Turton introduced Dr. E. Meltzer, and Dr. Goldberg introduced Mr. N. Kretzmar.

4. *Illness of Dr. Pirie:* The Chairman referred to the illness of Dr. J. Harvey Pirie and said that the Executive Committee had sent a telegram of sympathy to him. Council *AGREED* that a letter of sympathy be sent to Dr. Pirie on its behalf.

The Chairman then made announcements regarding certain events which had been arranged to take place during the week.

5. *Consideration of Agenda:* The Secretary stated that the Executive Committee had considered the Agenda and felt that Contract Practice matters should be taken together and separated from the rest of the Agenda. It also recommended that Friday should be set aside for Contract Practice matters. Council *AGREED.*

He stated also that the Executive Committee had agreed to recommend to Council that the time limit of five minutes for all speakers, except those presenting reports, be strictly adhered to. The Chairman stated that although a certain amount of discretion might be used by him, in general the time limit would be strictly applied. Council *AGREED.*

The Secretary reported that the Executive Committee had also agreed to recommend that immediately after confirmation of the Minutes, the item 'Honours' should be considered, to enable certain awards to be made at the Adjourned Annual General Meeting that evening. Council *AGREED.*

6. *Minutes* of the Meeting held at Vereeniging on 11, 12 and 13 April, 1956, were *CONFIRMED and SIGNED.*

7. *Honours:* The Secretary reported that the Executive Committee had considered the names of five persons recommended by the Cape Western Branch for Emeritus Membership: Dr. J. Luckhoff, Dr. J. G. Luyt, Dr. C. Muller, Dr. Elsie Chubb and Dr. H. M. Griffiths. The Executive Committee had dealt with the matter in order that the Certificates could be prepared in time for presentation at the Adjourned Annual General Meeting. The Executive Committee had approved these awards and it now remained for Council to confirm the Committee's action. Council *CONFIRMED* the action of the Executive Committee.

The Secretary then submitted four nominations for the award of the Bronze Medal: Dr. C. M. Grundlingh (Northern Transvaal Branch), Dr. R. Lance Impey, Dr. J. P. de Villiers and Mr. L. B. Goldschmidt (posthumous) (Cape Western Branch). Drs. Impey and de Villiers absented themselves from the meeting at this stage. Ballot votes were taken, the results being as follows:

Dr. Grundlingh: A citation from the Northern Transvaal Branch was read, and Drs. Shadick Higgins and Owen-Smith were appointed scrutineers. The Chairman announced that the award had been *APPROVED*, and this announcement was received with acclamation.

Mr. L. B. Goldschmidt: A citation from the Cape Western Branch was submitted. The scrutineers appointed were Dr. Marchand and Mr. McMurray. The Chairman announced that this award had been *APPROVED.*

Dr. R. Lance Impey: A citation from the Cape Western Branch was submitted. Dr. Owen-Smith and Mr. McMurray were appointed scrutineers. The Chairman announced that this award had been *APPROVED*, and the announcement was received with acclamation.

Dr. J. P. de Villiers: A citation from the Cape Western Branch was submitted. The scrutineers appointed were Dr. Marchand and Mr. McMurray. The Chairman announced that this award had been *APPROVED*, and the announcement was received with acclamation.

Drs. de Villiers and Impey returned to the meeting and thanked Council for the honour conferred on them.

8. *Election of Vice-President/President-Elect:* The Chairman called for nominations for the election of Vice-President/President-Elect. Dr. Rossiter stated that the Natal Coastal Branch had pleasure in nominating Dr. H. Grant-Whyte. This was seconded by Mr. Armitage. There were no other nominations and Dr. Grant-Whyte was declared elected by unaminous vote.

Dr. Grant-Whyte replied, saying that he was deeply sensible of the great honour conferred by Council on him and on his Branch. *Acclamation.*

9. *Association's Silver Medal:* The Chairman referred to the relevant item in the Report of the Head Office and Journal Committee and amplified the proposed scheme, stating that by means of this Medal the Association would have an opportunity of recognising the service to medicine and to humanity of those who had devoted themselves to medical research. Rules for the conferment of the Medical were presented, and it was proposed by the Chairman, seconded by Dr. J. S. du Toit, that the Association institute the award of a Silver Medal for this purpose and that the relevant rules be approved. Council *AGREED.* The rules are as follows:

1. The Association's Silver Medal shall be awarded at the discretion of the Federal Council to members of the Association or any other persons resident in South Africa who, through original research, have made valuable contributions to the advancement of medical science and the art of healing.

2. Any member of Federal Council may propose candidates for the receipt of the medal. The nominations must be made in writing, bear the signature of the proposer and two other members of Council and be enclosed in a sealed envelope. This must be addressed to the Secretary of the Association and must be in his hands at least five weeks prior to a meeting of Federal Council.

3. The Secretary shall submit the nomination to the Executive Committee of Council. The Executive Committee shall make a recommendation to Federal Council as to whether the award should be made or withheld, but the Council is not bound to accept the recommendation of the Executive Committee.

4. Awards may be considered and made at any meeting of Federal Council, provided that not more than two awards may be made in any calendar year.

5. The voting of Council shall be by ballot and no award shall be made unless the candidate receives not less than three-quarters of the votes of members of Council present at the meeting either in person or by proxy.

6. All deliberations and voting on awards shall be considered as strictly confidential and shall not be disclosed to anyone except that the names of recipients shall be published in the *Journal* with a statement of the service for which the award is made.

7. The name of the recipient, his academic and professional qualifications and the date of the award shall be inscribed on each medal.

8. Nothing in the foregoing regulations shall prevent the Council from awarding the medal posthumously for services as defined under regulation (1), provided such posthumous awards are made on the same conditions as those to living persons.

The Chairman went on to state that he and certain others had great pleasure in moving that the rules which had been passed on this occasion should be suspended in order that Council might have the opportunity of considering the immediate award of the Silver Medal to Prof. M. van den Ende, the Dean of the Faculty of Medicine of the University of Cape Town. Council *AGREED* to the suspension of the rules.

Dr. Sichel then described the work of Prof. van den Ende, and Council *AGREED unanimously* to the immediate award of the Association's Silver Medal to Prof. van den Ende. *Acclamation.*

MATTERS ARISING OUT OF THE MINUTES

10. *Termination of Membership of Full-time Medical Officer:* It was reported that the medical officer concerned had resigned

his membership of the Association before any investigation into his conduct had taken place.

The Secretary reported that the Executive Committee had agreed to recommend to Council that the resignation of the medical officer be accepted and that suitable amendments be made to Article 9 of the Association's Constitution to provide a procedure for dealing with cases involving expulsion.

Dr. Struthers said that he felt that the ideal procedure would be for the Ethical Committee of a Branch to carry out any investigation in such cases and that their findings should be referred to the Central Ethical Committee which would have the responsibility of making any recommendation to Federal Council for Council's decision.

It was proposed by Dr. J. S. du Toit, seconded by Dr. Gluckman and *RESOLVED* that the Executive Committee's recommendation be accepted.

Council *AGREED* further that the Head Office and Journal Committee be empowered to go further into the matter.

11. *Visit of Dr. T. C. Routley:* The Secretary stated that Council had expressed the wish that Dr. Routley should be invited to visit the Union in order to attend the Congress in 1957 and to address meetings. The Council had felt that not enough was known in this country of the work of the World Medical Association. Dr. Routley's place in world medical affairs was briefly described, and it was stated that Dr. Routley's visit would be discussed by the Council of the World Medical Association at its meeting in Havana in October.

The Secretary stated that the Executive Committee had agreed to recommend to Council that if Dr. and Mrs. Routley should visit the Union, the Association should bear the cost of their travelling within the Union and that subsistence and entertainment expenses should be the responsibility of the Branch centres visited.

It was proposed by Dr. Theron, seconded by Dr. Thompson and *RESOLVED Nem. Con.* that the recommendation of the Executive Committee be accepted.

Dr. Struthers took the Chair.

12. *Recognition of Special Departments in Approved Hospitals—Registration of Specialists:* A letter was submitted from the S.A. Medical and Dental Council, stating that the Council was unable to give recognition to hospitals other than teaching hospitals for the minimum period of training as a specialist.

The Secretary stated that the Executive Committee had agreed to recommend to Council that the S.A. Medical and Dental Council be approached in order to see if it would be prepared to recognise hospitals for specialist training if a definite teaching programme was followed by senior practitioners on the staffs.

Discussion followed in which it was stated that the Medical Council should be asked to lay down the minimum standards for the training of post-graduate students, so that if a hospital which was not concerned with the teaching of under-graduate students was able to fulfil the requirements of the Medical Council in regard to the teaching of post-graduate students the necessary recognition might be obtained from the Council.

It was finally proposed by Mr. Armitage, seconded by Dr. Meltzer and *RESOLVED* that the recommendation of the Executive Committee be accepted.

13. *Ophthalmologists and Optometrists:* Various memoranda and items of correspondence were submitted. These were amplified at length by Dr. Sichel.

The Secretary stated that the Executive Committee had agreed to recommend to Council that Drs. Sichel and J. S. du Toit draw up a memorandum embodying the views expressed by Dr. Sichel at the meeting, for submission to the S.A. Medical and Dental Council. The Executive Committee had further agreed to recommend to Council that the ruling given at the last meeting regarding the right of a Branch to give consent for lectures be reaffirmed.

After short discussion it was proposed by Dr. Sichel, seconded by Mr. Armitage and *RESOLVED* that the recommendations of the Executive Committee be accepted.

14. *Urological Appointments—Mines Benefit Society:* Council *AGREED* that this item be deferred until the last day of the meeting when all Contract Practice matters would be discussed.

15. *Legal Opinion regarding Corporate Bodies:* Correspondence and a legal opinion were submitted.

The Secretary stated that the Executive Committee had agreed to recommend to Council that no further action be taken.

It was proposed by Dr. Gluckman, seconded by Mr. Wolfowitz and *AGREED* that discussion on this matter be deferred until the afternoon.

16. *Legal Defence of Doctors:* The Secretary stated that the Executive Committee recommended that discussion of this item be deferred until half-past-two that afternoon so that Dr. A. French, the Secretary of the Medical Protection Society, could address the Council on the possibility of setting up a branch of the Society in the Union. Council *AGREED.*

17. *Amendment of Congress Rule* 1(16): Dr. Grant-Whyte asked Council's permission to withdraw his Notice of Motion. Council *AGREED.*

18. *Estates Duty Tax:* A letter was submitted from the Commissioner for Inland Revenue, from which it was *NOTED* that the Association's Benevolent Fund would in future be exempt from Estates Duty Tax.

19. *Closed Panels—Notice of Motion to Review and Rescind Resolution Taken at Last Meeting:* Dr. Gluckman drew attention to the fact that three memoranda regarding the Mines Benefit Society and the Southern Transvaal Branch had only become available at the commencement of the meeting. He suggested, and Council *AGREED*, that discussion on this matter be deferred until the next day.

20. *Rules of S.A. Medical and Dental Council—Rule* 1, *General Note* (ii): A letter was submitted from the Registrar of the S.A. Medical and Dental Council, in which it was stated that the Executive Committee of the Council saw no reason why the Note should be changed. Council *NOTED* this.

21. *The Function of the Intern in the Hospital:* A letter was submitted from the S.A. Medical and Dental Council, in which it was indicated that the Council was concerned with the training of interns rather than the supply of interns in hospitals.

The Secretary stated that the Executive Committee felt that the reply of the Medical Council should be noted at this stage and that the matter should receive further attention when Mr. McMurray reported on the activities of the Sub-Committee on Medical Education and Internships. Council *AGREED* accordingly.

22. *British Commonwealth Medical Conference*, 1957: A letter from the Honorary Secretary and Treasurer of the British Commonwealth Medical Conference was read. The letter stated that the next Conference would be held at B.M.A. House, London, during July 1957, and that delegates would also attend the Annual Meeting of the British Medical Association at Newcastle-upon-Tyne following the Conference. The letter contained three questions which Council agreed should be dealt with seriatim.

The Secretary read a recommendation from the Executive Committee, that the Medical Association of South Africa be represented at the British Commonwealth Medical Conference in 1957 and that the representative be the Secretary of the Association.

It was proposed by Dr. Schaffer, seconded by Dr. Theron and *RESOLVED* that the recommendation of the Executive Committee be accepted.

In regard to the question of whether the Medical Association of South Africa would remain a member of the British Commonwealth Medical Conference and contribute its share to the expense pool irrespective of whether it sent a delegate to the Conference or not, it was proposed by Dr. Sichel, seconded by Dr. de Villiers and *RESOLVED* that the Medical Association of South Africa should continue to remain active as a member of the Commonwealth group and should contribute its proportionate share to the pool.

It was proposed by Dr. Theron, seconded by Dr. Gluckman and *RESOLVED* that when a delegate combines attendance at the Conference with a mission which he would have undertaken in the locality of the Conference even if the Conference had not been meeting, only an appropriate proportion of his expenses should be a charge on the Conference pool, and that this proportion should be on a basis of fifty-fifty.

It was noted that the Association would be entitled to have more than one representative at the Conference, although the expenses of only one delegate would be met by the pool. As Dr. Black was to be in the United Kingdom next year at the time of the Conference, Council *AGREED* that he should be a second representative of the Medical Association of South Africa.

23. *Motor Car Insurance for Medical Practitioners:* A letter on this subject was submitted from the Northern Transvaal Branch.

It was proposed by Dr. Sichel, seconded by Mr. Wolfowitz and *RESOLVED* that it be an instruction to the Head Office and Journal Committee to approach Messrs. Edward Lumley & Sons

with a view to reviewing the agreement between them and the Association re motor car insurance, in the light of the experience so far gained and in view of criticism by members in specific cases.

24. *Itinerant Practice:* Representations from the Natal Inland Branch were submitted.

It was proposed by Dr. Thompson, seconded by Mr. Armitage and *RESOLVED* that the matter be dropped.

25. *Advertisements in 'Medical Proceedings':* The Secretary drew attention to correspondence on this subject which had been circulated. Council *AGREED* that the correspondence be *NOTED*.

FINANCIAL STATEMENT

26. *Financial Statement of Honorary Treasurer:* An interim report on the financial position of the Association had been submitted, and this was amplified by Dr. J. S. du Toit, the President.

Arising out of the Report, it was proposed by Mr. Wolfowitz, seconded by Dr. Gluckman, that the *S.A. Journal of Laboratory and Clinical Medicine* be abandoned as a publication of the Association.

Discussion followed, during which a number of contrary opinions were expressed. An amendment was proposed by Dr. Landau, seconded by Mr. McMurray, that the matter be referred back to the Head Office and Journal Committee for investigation. An addendum to the amendment was accepted, reading: 'and that it report back to the next meeting of Federal Council.'

In the circumstances Mr. Wolfowitz and his seconder agreed to withdraw their proposal.

The amendment was then put to the meeting as a substantive motion and was *CARRIED Nem. Con.*

Dr. du Toit then moved the adoption of his Report, which was *CARRIED*.

27. *Resignation of Dr. J. S. du Toit and Appointment of New Honorary Treasurer:* Dr. du Toit stated that after thirty years' service as Honorary Treasurer of the Association, he felt that he should now resign and allow someone else to take over the office, particularly as the Association had seen fit to elect him to be its President. He proposed that Mr. J. D. Joubert succeed him as Honorary Treasurer.

A number of members spoke in appreciation of the services of Dr. du Toit, and Dr. Sichel seconded Dr. du Toit's proposal that Mr. Joubert be appointed as Honorary Treasurer. Council *AGREED* unaminously to this appointment.

Dr. Sichel then proposed a vote of thanks to Dr. du Toit for his many years of loyal service to the Association. This was *CARRIED* with acclamation.

Council adjourned for lunch from 1.5 p.m. to 2.35 p.m.

On the resumption, Dr. Sichel took the Chair and made certain announcements regarding the Adjourned Annual General Meeting.

LEGAL DEFENCE OF DOCTORS

28. *Legal Defence of Doctors* The Chairman introduced Dr. A. French, the Secretary of the Medical Protection Society.

The Secretary gave a brief resumé of the events leading up to the visit of Dr. French and the purpose of the visit.

Dr. French then addressed the Council and thanked the Chairman of Council for the invitation to the Union in order to discuss the question of medical protection with a view to establishing a branch of the Medical Protection Society in South Africa. He spoke briefly on the history of legal defence for doctors and explained how his Society had been built up during the last sixty years. He referred to a memorandum which he had prepared and which had been circulated to members of Council, in which was set out a scheme of co-operation between the Society and the Medical Association, whereby members of the Association could join the Society and obtain the protection and benefits of membership which were offered to the 35,000 members of the Society all over the world. He mentioned briefly the subscriptions which would be payable by members in South Africa and which compared very favourably with those already paid as insurance premiums.

The Chairman asked Dr. French to set out for the Council an example of how the Society would work in the Union. This was done by Dr. French, from the time that a complaint might be lodged against a member until settlement was reached.

Dr. French's report was received with acclamation and the Chairman thanked him for having addressed the Council. He suggested that Dr. French answer any questions which members might wish to put to him.

Mr. Wolfowitz asked two questions: (1) Whether legal defence would be afforded to a member in the event of a disciplinary enquiry made by the S.A. Medical and Dental Council; (2) Whether a theatre sister employed by a surgeon would be covered by the surgeon's membership of the Society. Dr. French said that the answer to both questions was in the affirmative.

In reply to a question by the Chairman, Dr. French said that the policy of the Society was to protect a member whose professional reputation had been impugned, no matter in which branch of the law the complaint might be made. If a doctor was charged with a criminal offence and the facts clearly showed that it arose in the course of his professional duties, then it would be within the scope of the Society to provide him with every possible legal assistance. He reminded members, however, that it would be illegal to indemnify a convicted criminal against the penalties inflicted by the court, i.e. to pay or undertake to pay anyone else's fine. He mentioned also that a doctor convicted of a criminal charge inevitably had to appear before the Medical Council and that one could not use the Council as an appeal court, and so it was often a case of pleading in mitigation only, so that the charge did not amount to infamous conduct.

In reply to a further question, Dr. French said that criminal abortion was an exception.

In answer to further questions, Dr. French mentioned that his Society had an affiliation with the Queensland Branch of the British Medical Association in Australia and also with the New Zealand Branch of the British Medical Association. In those countries the Association carried out a certain amount of administrative work on behalf of the Society, and a portion of the subscription paid was remitted to the Association's Branches for the work done.

Dr. Gluckman asked what the geographical limits of cover were in the Society's scheme, and Dr. French replied that the whole world was covered except the United States of America where the costs of damages and litigation were so high that the Society could not compete without very special rates.

Dr. Epstein asked whether the parent body would accept full responsibility for all claims in South Africa. Dr. French replied that it would, within the scope of the Society and the limit of the total amount of indemnity as chosen by the member. Within that limit there would be no restrictions.

After various other questions had been put and answered, the Chairman thanked members for their questions and said that he felt that the stage had been reached where the recommendation of the Head Office and Journal Committee could be read. This had been put to the Executive Committee and had been endorsed by that Committee. It read as follows: 'The Head Office and Journal Committee agreed to recommend to Council that an agreement be reached with the Medical Protection Society of London in order that a branch of the Society be formed in South Africa, to be operated in conjunction with the Medical Association of South Africa.'

Dr. Goldberg proposed accordingly, seconded by Dr. Agranat.

It was *NOTED* that a small Advisory Committee would be set up to assist the Secretary and the appointed solicitors to manage the South African end of the Society's business.

On being put to the vote, the proposal was *CARRIED* unanimously.

The Chairman then proposed that a vote of thanks be sent to the Medical Protection Society in London for having sent Dr. French to the Union. He also proposed a vote of thanks to Dr. French for having met the Council and others and for his help. He said he hoped that a successful culmination of these negotiations would soon take place. These votes of thanks were accorded with acclamation.

Dr. French said that he was grateful for the welcome and hospitality which had been extended to him, and he thanked the Council for listening to what he had had to say. He was sure that only good would come of the negotiations. *Acclamtion.*

29. *Introduction of Honorary Treasurer:* At this stage Mr. J. D. Joubert, the newly-elected Honorary Treasurer, was introduced to Federal Council. Mr. Joubert thanked the Council for the honour bestowed on him and said that he would do his best to carry out the work of the Honorary Treasurer. *Acclamation.*

REPORT OF EXECUTIVE COMMITTEE

30. *Report of the Executive Committee:* The Report was presented as follows:

'There have been no formal meetings of the Executive Committee since the last meeting of Federal Council to the time of drawing up this Report. The work of the Committee has been undertaken by correspondence.

'The first matter dealt with was by means of a circular to the Committee, dated 18 April, when the Chairman of Council asked whether the Committee agreed to the nomination of Dr. A. H. Tonkin for election to the Council of the College of Physicians and Surgeons of South Africa. The Committee agreed that Dr. Tonkin might be nominated to serve on the College Council if elected.

'On 11 June the Legal Opinion regarding Corporate Bodies Practising Medicine was circulated and the opinions of the Committee regarding action were asked for at that stage.

'On 26 June the Committee agreed that the next meeting of Federal Council should be held on 3, 4 and 5 October, 1956.

'On 28 June the opinions of the Executive Committee regarding the Legal Opinion regarding Corporate Bodies Practising Medicine were circulated and the members were asked to record whether or not the matter should be held over for discussion and decision by Federal Council rather than that the Executive Committee should make a decision. The consensus of opinion was in favour of delay until the whole Council had had an opportunity to discuss the matter.

'After the Association Newsletter had received undersirable publicity in the newspapers, a circular dated 19 July was sent to the Executive Committee, in which an opinion was sought as to whether any further newsletters should be sent out prior to the meeting of Federal Council. The Committee decided that no further newsletters should be sent.

'On 19 July a letter from the Convener of the Workmen's Compensation Act Sub-Committee was sent to the Executive Committee, in which it was suggested that the Sub-Committee be "given plenary powers to conclude an arrangement with the Workmen's Compensation Commissioner" regarding the new tariff of fees. The Committee agreed that in view of the urgency of the matter the Sub-Committee should be given power to act.

'On 20 August a circular was addressed to the Committee regarding the Hamilton-Maynard Memorial Medal for 1955. The Head Office and Journal Committee had recommended that two Medals be awarded for the year 1955, and as there was no precedent for this the Committee was asked to give an opinion. At the time of drawing up this Report, no definite decision has been reached.'

Council *AGREED* that the Report of the Executive Committee be *CONFIRMED*.

Certain matters arising out of the Report were then dealt with seriatim.

31. *Association Newsletter:* Discussion ensued and it was proposed by Dr. J. S. du Toit, seconded by Mr. McMurray, that the issue of newsletters be left in abeyance until some future date.

An amendment was proposed by Dr. Lewis Robertson, seconded by Dr. Black, that the question of newsletters be left to the discretion of the Executive Committee.

On being put to the vote, the amendment was *LOST*.

Dr. du Toit's proposal was then put to the vote and *CARRIED*, with two dissentients.

Council then agreed to deal with certain matters which had been raised at the meeting of the Executive Committee held on the previous day. These were as follows:

32. *Remuneration of Doctors under Third Party Insurance:* The Secretary intimated that this matter had been raised by the Northern Transvaal Branch and that the Executive Committee had agreed to recommend to Council that the matter be referred to the Parliamentary Committee for attention. Council *AGREED*.

33. *Orthopaedic Surgeons' Group—Amendments to Constitution:* The Secretary stated a number of proposed amendments to the Constitution of this Group had been submitted. The Executive Committee had agreed to recommend to Council that these be referred to the Executive Committee for attention and action. Council *AGREED*.

34. *Anaesthetists' Group—Amendments to Constitution:* The Secretary reported that certain proposed amendments to the Constitution of this Group had been submitted, and that the Executive Committee had agreed to recommend to Council that these be referred to the Executive Committee for attention and action. Council *AGREED*.

35. *Training of Interns in Anaesthesia:* The Secretary outlined the correspondence on this subject which had taken place between the Anaesthetists' Group and the S.A. Medical and Dental Council, and stated that the Executive Committee had agreed to report to Council that it had decided to refer this matter to the Sub-Committee on Medical Education and Internships. *NOTED*.

36. *Formation of Vaal River Branch:* The Secretary stated that the Vereeniging Division of the Southern Transvaal Branch had requested Council to recognise it as a separate Branch of the Association, its area to incorporate Vereeniging and Vanderbijlpark magisterial districts.

Dr. Lewis Robertson suggested that the question of Sasolburg being included in the area of the new Branch be investigated, and it was *AGREED* that eventually any additions to the area should be determined in consultation with the Southern Transvaal and O.F.S. and Basutoland Branches.

The Honorary Assistant Secretary of the Southern Transvaal Branch, Dr. Gluckman, stated that his Branch had no objection to the formation of the new Branch.

Finally it was proposed by Dr. Chapman, seconded by Mr. Wolfowitz and unanimously *RESOLVED* that the formation of the Vaal River Branch be approved in principle, subject to the Constitution meeting with the final approval of the Executive Committee.

37. *Rate of Pay for Part-time Medical Officers—S.A. Society of Medical Women:* Correspondence on this subject was submitted and the Secretary stated that the Executive Committee had agreed to recommend to Council that this matter be referred to the Parliamentary Committee for action. Council *AGREED*.

38. *Legal Opinion re Corporate Bodies*: The legal opinion was submitted which was elaborated by Dr. Shapiro.

The Secretary stated that the Executive Committee had agreed to recommend to Council that no further action be taken.

It was proposed by Dr. Sichel, seconded by Dr. Troskie, that the recommendation of the Executive Committee be accepted.

An amendment was proposed by Dr. Shapiro, seconded by Dr. Turton, 'That in view of the fact that the legal opinion indicates that the Medical Association of South Africa has no *locus standi*, the Association should not proceed at this stage to take any action.'

Discussion proceeded and a second amendment was proposed by Dr. Gluckman, seconded by Mr. Wolfowitz, 'That a deputation of the Medical Association of South Africa should interview the Attorney General of the Transvaal and place all the facts, opinions and authorities before him and request him to take action for contravention of the Act by various corporate bodies.'

With the permission of his seconder, Dr. Shapiro asked that his amendment be withdrawn. Council *AGREED*.

Further discussion ensued, and it was proposed by Dr. Black that Council should adjourn and that the voting on this matter should take place on the following morning.

Council adjourned at 5.30 p.m.

THURSDAY, 4 OCTOBER

The meeting commenced at 9.40 a.m., Dr. Struthers being in the Chair.

At the commencement of the meeting it was generally agreed that Council would meet for an evening session.

38. (continued)—*Legal Opinion re Corporate Bodies:* After further discussion, Dr. Gluckman's amendment was put to the vote and *LOST* by 10 votes to 34.

Dr. Shapiro then sought to have the amendment which he had withdrawn, reinstated, and argument ensued on this point. Eventually the Chairman put it to the meeting as to whether they wished to vote on Dr. Shapiro's amendment. Council *AGREED*, with two dissentients. Dr. Shapiro's amendment was then read and put to the vote, and was *LOST* by 18 votes to 27.

The original proposal was then put to the vote and *CARRIED* by 28 votes to 13.

39. *Closed Panels:* Notice of Motion to review and rescind the resolution taken at the last meeting of Council had been received over the signatures of Dr. Agranat and Dr. Turton. A memorandum on this subject had been submitted and the Notice of Motion had been published in the *Journal* for general information.

Dr. Agranat spoke in regard to the memorandum and gave reasons why he considered it would be in the interests of the Association to rescind the resolution.

The resolution to rescind read as follows:

'In view of the considerable difficulties and embarrassment and probable unfavourable repercussions caused by an attempt to implement the resolution of Federal Council on the question of an open panel for all Benefit Societies, adopted at its meeting in April, 1956, we move that the resolution be rescinded and that Federal Council appoints a committee to investigate and report on the practicability and advisability of applying the open panel system to Benefit Societies.'

After long discussion it was proposed by Mr. Currie, seconded by Dr. Gluckman and *RESOLVED Nem. Con*, 'That the question be now put.'

The motion to review and rescind was then put to the vote and was *LOST*, having only three votes in its favour.

It was then proposed by Dr. Shapiro, seconded by Dr. Gluckman, 'That the policy of the Association, as defined in the previous resolution of Council, be reaffirmed, and that a committee be appointed to investigate and report on the best way of implementing this policy reasonably in the interests of the public and of the profession.'

An amendment was proposed by Dr. Waks, seconded by Dr. Ziady, 'That a sub-committee be appointed by Federal Council to explore ways and means of the practical application of the principle of free choice of doctor, with particular reference to Medical Benefit Funds, and that in the meantime Branches be allowed to use their discretion in respect of the present ruling of Federal Council.'

After further discussion, Dr. Waks's amendment was put to the vote and was *LOST*, there being seven votes in its favour.

Dr. Shapiro's resolution was then put to the vote and *CARRIED*, Drs. Ziady, Waks, J. G. A. du Toit, Vercueil, Epstein, Jabkovitz, Agranat and Struthers asked that their votes be recorded against the resolution.

Discussion followed regarding the appointment of a committee to undertake this task. It was proposed by Dr. Shapiro, seconded by Dr. Struthers and *RESOLVED* that the Executive Committee be appointed to do this work. Council further *AGREED* that the initiative should lie with the Cape Town members of the Executive Committee.

Council adjourned for lunch from 1 p.m. to 2.30 p.m.

On the resumption, Dr. Sichel was in the Chair.

40. *Federal Ethical Committee:* The Secretary stated that the Federal Ethical Committee had had to deal with no matters since the last meeting of Council and that there was therefore nothing to report. *NOTED.*

HEAD OFFICE AND JOURNAL COMMITTEE

41. *Report of Head Office and Journal Committee:* Dr. Sichel presented this Report, stating that there had been five ordinary meetings and two special meetings of the Committee since the last meeting of Council. The average attendance had been nine members.

The items of the Report were dealt with seriatim:

42. '*History of Medicine in South Africa*': It was reported as follows:

'The writing of this book has been completed and the typescript of all the chapters has been checked by the author. Certain additions in regard to the references have yet to be made and suitable illustrations have to be chosen. The Committee has obtained the opinion of a well-known South African writer that the substance of the book is excellent and that the book itself is well written and should be published without doubt. The Committee does not wish to proceed precipitately and would rather negotiate cautiously regarding its publication next year. It is felt that its chief concern is to see that a good book is published in the best way and to the best advantage rather than to hurry at this stage. In the circumstances it can be reliably expected that the book will be published in 1957, so marking the 30th year of the founding of the Association as an independent body.' *NOTED.*

43. *Appointment of Assistant Secretary:* The Report as submitted stated:

'Advertisements placed in the *Journal* resulted in two applications being made. Further information regarding the two applicants has been sought and at the time of writing this Report no definite recommendation to Council has been made.'

Dr. Sichel moved that Council go into committee.

Dr. Struthers arrived at this stage and took the Chair.

Council *AGREED* to go into committee.

After discussion in committee, Council *AGREED* to go out of committee and that the resolution taken in committee be confirmed. The resolution was as follows: 'Council having discussed the question of the appointment of an Assistant Secretary to act in the Transvaal, it is content to leave the final decision to the Executive Committee.'

44. *Appointment of Editor:* The Report as submitted stated:

'The post of Editor was advertised in the *Journal* and the *British Medical Journal* At the time of writing this Report the closing date for the receipt of applications has not yet been reached.'

The Secretary gave particulars regarding this appointment.

It was proposed by Dr. Shapiro and *AGREED* that Council go into committee.

After discussion in committee, it was proposed by Mr. Wolfowitz and *AGREED* that Council go out of committee.

The resolution taken in committee, which had been proposed by Dr. Shapiro and seconded by Mr. Wolfowitz, was then *CONFIRMED*, reading as follows: 'That the matter of the appointment of an Editor be referred back to the Head Office and Journal Committee to be dealt with in their discretion, so that the Committee shall be in a position to make a firm recommendation at the next meeting of Council.'

45. *Salary Scale of Business Manager:* It was reported as follows:

'Following the resolution of the last meeting of Council, the Committee considered the salary scale for the Business Manager and now recommends to Council that it should be £1,000×50—1,600 (basic).'

Council *AGREED* to the Committee's recommendation and also *AGREED* that Mr. de Kock be placed on the £1,300 notch of the new scale as from 1 January, 1957.

46. *Donations to Medical Libraries:* It was reported as follows:

'The Committee recommends to Council that a donation of £100 per annum, commencing in 1956, be made to the Medical Libraries of the Universities of Pretoria, Stellenbosch and Natal.'

Council *AGREED Nem. Con.* to the Committee's recommendation.

47. *Hamilton-Maynard Memorial Medal for* 1955: It was reported:

'The Committee considered the papers which had been submitted for publication in the *Journal* during 1955 and felt that there were two papers which both merited the award of the Medal. As there was no precedent for a double award being made, the matter was placed before the Executive Committee which agreed that it would be in order for two Medals to be presented. In the circumstances, the Committee has agreed that Hamilton-Maynard Medals be awarded to Mr. T. Schrire for his paper entitled "Modified radical Gastrectomy for Cancer of the Stomach", which appeared on Page 494 of the *Journal* of 22 May 1955, and to Dr. W. P. U. Jackson for his paper entitled "Osteoporosis—Commonest of Ali Diseases?", published on Page 885 of the issue of 17 September 1955.'

This was *NOTED* by Council.

48. *Leipoldt Memorial Medal for* 1955: It was reported as follows:

'The Committee has agreed to award this Medal to Dr. L. Solomon for his paper entitled "Acute Dilatation of the Stomach", published on Page 386 of the *Journal* of 23 April, 1955.'

This was *NOTED* by Council.

49. *Institution of Association's Silver Medal Award:* It was *NOTED* that this section of the Report had already been dealt with.

50. *Work Undertaken by Southern Transvaal Branch:* Memoranda on this subject were submitted and these were amplified by Mr. Wolfowitz who stated that the Branch office had done work for the Federal Council ever since 1946 and that there had been a tendency for this work to increase. He stated that the Branch would probably not be able to meet its commitments this year and asked that Federal Council make a grant of £500 to the Branch. In answer to a question, he stated that it was not intended that this should be an annual grant but that the grant of £500 should be for the purpose of meeting this year's commitments.

Dr. Struthers said that he was in favour of giving the grant to the Southern Transvaal Branch, and, indeed, had suggested that this be done a year or two ago. He felt, however, that a committee should be set up to investigate the situation of the work of the Association in the Transvaal.

Other members spoke in support of Dr. Struthers, and Mr. Wolfowitz said that he would be quite happy to see a committee appointed to go into the affairs of the Southern Transvaal Branch.

It was proposed by Dr. Grant-Whyte, seconded by Dr. Schaffer and *RESOLVED* that a grant of £500 be made to the Southern Transvaal Branch forthwith to defray expenses incurred by the Branch on behalf of the Association from 1946 to 1956.

It was proposed by Dr. Purcell, seconded by Dr. Grant-Whyte and *RESOLVED* that a committee of two persons be appointed to investigate the work of the Association in the Transvaal.

Mr. Wolfowitz thanked the Chairman and members of Council for the sympathetic hearing which they had given to the request of his Branch.

Dr. Sichel then moved the adoption of the Report of the Head Office and Journal Committee. This was *CARRIED*.

MANAGEMENT COMMITTEE OF BENEVOLENT FUND

51. *Report of Management Committee of Benevolent Fund:* A Report was submitted, in which it was stated that two meetings of the Committee had been held since the last meeting of Council, the average attendance being eight members.

The items of the Report were dealt with seriatim:

52. *Death of a Beneficiary:* It was reported as follows:

'In June Dr. T.H.T.B. died and the Southern Transvaal Branch is investigating the position of his widow. In the meantime the grant of £12 10s. 0d. per month which was paid to him is being continued as a grant to his widow. Further information is awaited from the Branch.'

This was *NOTED* by Council.

53. *Printing of Constitution:* It was reported as follows:

'The Constitution of the Benevolent Fund which was originally prepared in English and roneoed, is now to be translated into Afrikaans, and both English and Afrikaans versions will be printed in booklet form for distribution to members of the Association.'

Council *AGREED*.

54. *Endowment Scheme for Benevolent Fund:* The Committee had considered a memorandum submitted by the Secretary in regard to an endowment scheme for the Benevolent Fund. The basis of this scheme would be that members could take out an insurance policy which would be ceded to the Benevolent Fund so that the sum assured plus bonuses would become the property of the Benevolent Fund at maturity date.

Council *AGREED* that the Management Committee be empowered to act in this matter.

55. *Donation from Southern Transvaal Branch:* Mr. Wolfowitz, the Honorary Treasurer of the Southern Transvaal Branch, announced that a sum of £611 representing the proceeds of certain social functions arranged by his Branch, would be paid to the Benevolent Fund. This was *NOTED* with acclamation.

Dr. Sichel moved the adoption of the Report, which was *CARRIED*.

PARLIAMENTARY COMMITTEE

56. *Report of the Parliamentary Committee:* Dr. Struthers presented this Report and stated that his Committee had met on a few occasions since the last meeting of Council.

It was agreed that the matters contained in the Report be dealt with seriatim:

57. *Ethical Rules* 16, 17 *and* 19 *of S.A. Medical and Dental Council:* It was reported that after considerable delay a memorandum on this subject had been prepared for submission to Branches of the Association for consideration. Unfortunately this had been done too late for replies to have been received and for any result to have been made known to the Medical Council.

Council *AGREED* that the memorandum be published in the *Journal* and that a note be sent to Branches asking that meetings be convened at which the memorandum could be discussed. The Branches were then to submit their opinions, which would be correlated by the Parliamentary Committee. Council *AGREED*. further that the Parliamentary Committee should report back to Council at its next meeting before any result was passed to the Medical Council.

58. *Post Office Charges:* It was reported that as a result of representations made to the Under-Secretary for Telecommunications in regard to the cost of telephone diversion charges, it had been agreed by Treasury to reduce these prices, and that the new schedule of fees for diversions had been published in the *S.A. Medical Journal* of 9 June, 1956. *NOTED*.

59. *Income Tax Deductions in respect of Post-Graduate Study Expenses:* It was reported that provision had been made in the Income Tax Amendment Bill which had received the sanction of Parliament during the last Session, for doctors to claim as tax deduction expenses incurred by them in proceeding overseas for post-graduate study, provided that they had been qualified for at least three years and that the study period would last at least six months.

This was *NOTED*, but Council *AGREED* that the Parliamentary Committee should pursue the matter further.

Dr. Struthers then gave certain information which had been received from the Commissioner for Inland Revenue regarding entertainment expense deductions. Council *AGREED* that this information should be made known to the profession through the medium of the *Journal*, and *NOTED* Dr. Struthers's statement with acclamation.

Council adjourned for dinner at 6 p.m. and resumed at 8.15 p.m. Dr. Sichel was in the chair.

61. *District Surgeons:* Dr. J. G. A. du Toit reported on an interview which he and Dr. Troskie had had with the Secretary for Health. He stated that certain recommendations were to be made to Treasury which would be of benefit to District Surgeons and that a new pharmacopoeia was to be compiled and sent out.

It was stated that a new formula was being sought in regard to the payment of District Surgeons, and after discussion it was proposed by Dr. Troskie, seconded by Dr. Serfontein and *RESOLVED*: ‚Dat met in agneming van die feit dat daar geen uniformiteit van besoldiging van distriksgeneeshere bestaan nie en ook as gevolg van die gebruik van die Departement van Volksgesondheid om herhaaldelik werk op distriksgeneeshere to laai wat onder ‚Salaris' gedek word sonder vermeerdering van die besoldiging, hierdie Raad vaslê dat 'n redelike besoldiging vir 'n distriksgeneesheer se werk 'n minimum van £1 per uur sal bedra.'

Dr. Struthers, as Chairman of the Parliamentary Committee, then moved the adoption of the Report. In doing so, he stated that he wished to express thanks to Dr. J. G. A. du Toit who had acted as Chairman of the Committee during his absence overseas. This was accorded with acclamation, and the adoption of the Report was *CARRIED*.

62. *Report of Workmen's Compensation Act Sub-Committee:* Dr. Vercueil, Chairman of the Sub-Committee, presented this Report and stated that there was to be a new Tariff of Fees. This was being printed and would shortly be distributed to all members of the profession. *NOTED*.

The Chairman of Council proposed a vote of thanks to the Sub-Committee for the work which they had done. This was accorded with acclamation.

63. *Report of Sub-Committee to Prepare Memoranda on the Provision of Medical Services in relation to Medical Ethics: Various* documents in regard to this subject were *NOTED*.

Dr. Gluckman stated that there were still outstanding problems between the private pathologists in Johannesburg and the South African Institute for Medical Research. Mr. Wolfowitz proposed that the Augmented Executive Committee in the Transvaal take up the matter afresh with the Institute and that they co-opt a member of the Pathologists' Group to accompany them. After short discussion Council *AGREED*.

64. *Report of Sub-Committee on Rehabilitation:* In making a verbal report, Mr. G. T. du Toit, as Chairman of the Sub-Committee, stated that the Association had been asked to recommend the names of two persons, from whom the Minister of Labour would choose an alternate delegate to the National Council for Rehabilitation. It was proposed by Mr. G. T. du Toit, seconded by Dr. J. G. A. du Toit and *RESOLVED*, 'That Council appreciates the invitation to nominate a medical man for consideration by the Minister of Labour for appointment to the National Rehabilitation Council, and puts forward the names of Dr. E. B. Woolf and Dr. H. Moross, both of Johannesburg.'

The Report was *NOTED* by Council.

65. *Report of Sub-Committee to Advise Controller of Imports:* It was reported that the Sub-Committee continued to advise the Department of Commerce and Industries as well as the Pharmaceutical Advisory Committee on the essentiality and desirability of medical supplies imported into the Union. Thirty applications had been considered from importers, covering forty-two products, of which nineteen had not been recommended. One application

eived from a medical practitioner for importation of medical plies had been supported. It was reported also that a vacancy the Sub-Committee caused by the resignation of Dr. P. C. le, had not been filled.
Council *NOTED* the Report of this Sub-Committee.

Report of Sub-Committee on Groups within the Association: e Secretary submitted letters from four Groups within the sociation, two of which were opposed to any change in regard their ability to negotiate for fees.
After short discussion it was proposed by Dr. Shapiro, seconded Mr. Wolfowitz and *RESOLVED* that the matter be deferred il the next meeting of Council.

MEDICAL FEES FOR PRIVATE PRACTICE

Report of Sub-Committee on Medical Fees for Private ctice Dr. Landau, Chairman of the Sub-Committee, presented Report and went on to state that in the opinion of the Sub-mmittee no alteration in the Medical, Dental and Pharmacy was necessary in regard to Section 80 or Section 80(bis). He erred to a letter which had been received from the Registrar the S.A. Medical and Dental Council in connection with mplaints regarding medical accounts which were extremely on account of extensive examinations and investigations ich had been made and about which the patients had not been rmed beforehand by the attending practitioner.
t was proposed by Dr. Shapiro, and Council *AGREED*, that letter be published in the *Journal*. It was further *AGREED* an editorial article on this subject should be published in *Journal*, and that Branch Secretaries should receive copies the letter from the Council.

Charges for Procedures Requiring Teamwork by Specialists: Landau stated that he had attempted to obtain the opinions the Branches in regard to this subject, but so far few Branches d replied to the circular letter which had been sent to them. considering this matter, the Sub-Committee had agreed that breach of ethics was committed in charging a composite fee, the patient should know what procedures were performed d the fee for each, and in addition the patient should know names of the doctors comprising the team. If these points e not met, the alternative would be for members of the team end separate accounts.
This was *NOTED* by Council.

Report of Sub-Committee on Economics of Medical Practice: e Secretary read a letter from Dr. M. Shapiro, Convener of the b-Committee, dated 24 September.
Dr. Shapiro then reported on the activities of his Committee to the point when it had been decided to take no further action il the present meeting of Council following the refusal of the irman to allow an outright grant of £1,000 to be paid to the mmittee.
After short discussion it was proposed by Dr. Shapiro, seconded Dr. Gluckman and *RESOLVED* by 18 votes to 13 that Council nto committee.
Prolonged discussion followed, and eventually it was proposed Dr. Goldberg and *AGREED* that Council go out of committee. Council *AGREED* that the resignations of the members of the b-Committee, which had been tendered individually, should be rded out of committee. It was generally *AGREED* that the pointment of a new Sub-Committee should be dealt with on following day.

Council adjourned at 11.45 p.m.

FRIDAY, 5 OCTOBER

e meeting commenced at 9.20 a.m., Dr. Sichel being in the air.

CONTRACT PRACTICE

port of Central Committee for Contract Practice: Dr. Vercueil, airman of the Committee, presented the Report as follows:

Tariff of Fees: A Report of the meeting of the Central mmittee for Contract Practice held on 28 August, 1956, was mitted. This included revised schedules of fees for Anaesthetics, naecology, Ophthalmology, Otorhinolaryngology, Physicians, stic Surgery, and Psychiatry, Neurology and Neuro-surgery. th one minor amendment, Council *AGREED* that these edules of fees should be *ACCEPTED*.

Metal Box Company of S.A. Ltd. Medical Aid Society: It s reported that negotiations were continuing regarding the proval of this Medical Aid Society. The Committee recommended that the matter be deferred for a further six months. Council *AGREED*.

Sasol Medical Aid Society: It was reported that members of the Executive of the Committee had met representatives of the Society and that in view of all the circumstances which had been explained it had been agreed that the Society should be converted to a Benefit Society on an open panel basis for general practitioners and at Medical Aid rates for specialist services.
Council *AGREED* with this arrangement and *NOTED* that the Society had still to obtain final recognition from the O.F.S. and Basutoland Branch.

Northern Association of Medical Aid Societies: An explanation was given regarding the circumstances which had led Council to pass a resolution withdrawing recognition from this Association, and the Committee recommended that Council rescind its resolution taken at the previous meeting.
It was proposed by Dr. Agranat, seconded by Mr. Armitage and *RESOLVED* that the resolution withdrawing recognition from the Northern Association of Medical Aid Societies be rescinded.

Income Average and Income Ceiling for Members of Medical Aid Societies: A Report of a further meeting of the Central Committee for Contract Practice held on 2 October, 1956, was submitted. The Committee had recommended that the income average and income ceiling for members of Medical Aid Societies should be altered so that the average figure should be increased from £700 to £850 (basic). Council had deferred the matter.
Having given this matter further consideration, the Committee now recommended to Council that the average income limit be £1,100 inclusive of cost-of-living allowance. The Committee also recommended that the £2,500 (gross) ceiling should be applied to all Societies for continued recognition by the Association.
During discussion of this subject, it was proposed by Dr. Shapiro, seconded by Mr. Wolfowitz, that the above figures should be based on total nett income, from whatever source. On being put to the vote, this was *CARRIED Nem. Con.*, as was the Committee's recommendation.
Mention was made of the question of members of Medical Aid Societies whose incomes increased during the latter years of their service to an amount greater than £2,500. It was proposed by Mr. Currie, seconded by Dr. Gluckman, that such members should be allowed to retain their membership of a Society but should be liable to the payment of private fees. On retirement they might be allowed to revert to ordinary membership of the Society if their income fell to a level below the £2,500 ceiling. The Chairman of the Committee said that he heartily welcomed this resolution. On being put to the vote, the resolution was *CARRIED Nem. Con.*

Tariff of Minimum Fees: It was reported that the Committee considered that it was unable to set up a tariff of minimum fees as a guide to Branches, on which they could base loadings for the various parts of their Branch areas, as set out in a resolution contained in Minute 25(*e*) of the Council meeting held in April, 1956.
After discussion of this subject, it was proposed by Dr. Struthers, seconded by Dr. Shapiro, that the resolution to which reference had just been made be rescinded. They gave notice of motion accordingly, which was *ACCEPTED* by Council.
After further discussion Council *AGREED* that the Associate Secretary should circulate a memorandum to Branches for their guidance.

Payment to Mines or Other Concerns which Provide and Pay for the Entire Medical Service of Their Employees: It was stated that the Committee was of opinion that such an appointment could not be classed as a Benefit Society appointment but rather that it fell into the usual class of mine appointments and therefore did not fall within the province of the Committee. Council *AGREED*.

Ruling on Open Panels: It was reported that the Northern Transvaal Branch had drawn attention to an alleged 'ruling' of the Chairman of the Committee that in future general practitioners on Benefit Society panels were to be paid on a *per capita* basis and all specialists at Medical Aid rates. It was stated that the Committee was satisfied that there had been a misunderstanding in that the Chairman had given an explanation to representatives of a certain Benefit Society in regard to the operation of their own Fund in the future but that this was not intended to be a ruling. *NOTED*.

80. *Transvaal Clothing Industry Medical Aid Society:* It was reported that there had been difficulty in implementing the Council's resolution which required payment by the Society to be made to the domiciliary doctor who would make arrangements for consulting room services to the patients on his panel. It was stated that a satisfactory solution had been reached between the Executive Committees of the East Rand Branch and the Southern Transvaal Branch.

Mr. Wolfowitz moved that this item be noted, and Council *AGREED*.

81. *Sick Funds of Industrial Councils:* It was reported that the Southern Transvaal Branch had requested that Council debate the question of medical services in respect of industrial councils which were set up according to legislation by mutual agreement between employers and employees in any particular industry and on which representation of both parties was equal. It was recognised that some such industrial councils established Sick Funds to which both employer and employee contributed, and on the Management Committee of which the representation of both parties was equal. It was stated that the Committee considered that when any approach was made by any of these Sick Funds for approval of appointments, they should conform to the rules of the Medical Association in order to be recognised by any Branch of the Association. Council *AGREED*.

82. *Rules for Sick Benefit Societies:* It was reported that the Cape Western Branch had submitted that in view of the introduction of the open panel system, the paragraph in the rules of the Association requiring a minimum number of 100 members should be withdrawn. It was stated that the Committee supported this suggestion. Council *AGREED*.

83. *Payment for Post-operative Care:* It was reported that the Cape Western Branch had submitted a request from the Ear, Nose and Throat Surgeons' Group that Medical Aid Societies should be asked to pay for the services of general practitioners when they were required to give treatment during the period of convalescence of a patient, as specialists were not allowed to do domiciliary visiting. The Branch also submitted that this procedure should apply in respect of all surgical specialities. It was stated that the Committee had rejected this proposal as surgical fees included all post-operative care, and any service of a general practitioner should be remunerated by the surgeon in charge of the case.

Council *AGREED* to support the Committee.

84. *Amendments to Constitutions:* It was reported that the Committee had agreed to amendments in the Constitutions of a number of Societies. These amendments affected only the internal administration of the Societies or referred to increases in subscriptions and benefits. The relevant Societies were as follows:

(*a*) Argus Medical Benefit Society (Request for amalgamation of all existing societies of the Argus Group).
(*b*) Bloemfontein Municipal Employees Medical Aid Society.
(*c*) E.P. Newspapers Medical Aid Society.
(*d*) Municipal Employees Medical Aid Society, Durban.
(*e*) Northern Rhodesia European Civil Servants' Association Medical Aid Fund.
(*f*) S.A.A.M.E. Medical Aid Fund.
(*g*) Santam-Sanlam Siektefonds.
(*h*) Shell Medical Aid Society.
(*i*) Standard Brass Medical Aid Society.
(*j*) Stuttafords Medical Aid Society.
(*k*) 'Rennie' and 'The Consolidated' Employees' Medical Aid Fund.
(*l*) United Banks' Medical Aid Society.

The Committee also recommended to Council that amendments in the Constitutions of three other Societies be accepted as conforming to the requirements of the Association. These Societies were:

(*a*) African Explosives Medical Aid Society.
(*b*) Civil Service Medical Benefit Association.
(*c*) Transvaal Society of Accountants' Medical Aid Society.

It was proposed by Mr. Wolfowitz, seconded by Dr. Struthers and *RESOLVED* that the amendments in all these cases be approved.

85. *New Applications for Approval:* The Committee recommended to Council that the following new Societies be approved:

(*a*) General Mining (Associated Companies) Medical Aid Society.
(*b*) South Atlantic Corporation Medical Aid Society.

Council *AGREED* to the recognition of these two new Socie

Arising out of this matter, it was proposed by Dr. Strut that the question of guaranteeing the full payment of doc accounts by Medical Aid Societies should be referred back to Committee for consideration. Council *AGREED*.

86. *Societies to be Removed from the Approved List:* Committee recommended that the Matabeleland Medical Society and the Springbok Medical Aid Society be removed f the list of approved Societies. Council *AGREED*.

87. *Tariff of Fees for Dermatology:* A schedule of fees dermatological procedures was submitted, and Council *AGRE* that these fees be *APPROVED*.

88. *Tariff of Fees for General Practitioners:* It was repo that after the tariff of fees for general practitioners had b accepted at the last meeting of Council. the General Practition Group in the Southern Transvaal Branch area had reque that they be revised and had submitted a revised schedule.

It was stated that the Committee had considered the ma and had agreed not to recommend to Council that the sched be accepted.

Dr. R. C. de Kock spoke in favour of the new suggested f and while Dr. Shapiro expressed himself in favour of the Com tee's opinion he proposed that a fee of £15 15s. 0d. for a confine by a general practitioner should be approved. This was secon by Dr. de Kock but, on being put to the vote, it was *LOST*, t being only seven votes in its favour.

Council then *AGREED* to support the Committee's opin

89. *Telephone Consultations:* It was stated that the Commi could not recommend to Council that there be fees for teleph consultations.

Council *AGREED* that this be *NOTED*.

90. *Fees for Neuro-Surgery:* It was stated that the Med Aid Societies has asked that a maximum fee for pre-opera procedures should be laid down if followed by an operation, the costs of such operations and investigations could be extrem high. The Neurosurgical Group had indicated that they w not prepared to consider a maximum fee.

Council *AGREED* that the Committee should discuss matter with the Group once again.

91. *Advisory Council of Medical Aid Societies:* The Commi brought to the notice of Council a memorandum expressing views of the Advisory Council of Medical Aid Societies on revised schedules of fees which had so far been referred to Med Aid Societies for acceptance. The memorandum sought to k the reasons why the high increases should be justified.

Council *AGREED to NOTE* the memorandum.

92. *Mutual Medical Aid Society of* 1954: The Committee d attention to an advertisement for this Society which had appea in the 'Star' of 17 September 1956.

Council *AGREED* that the advertisement be ignored.

93. *Mines Benefit Societies Medical Officers' Group:* It stated that the Executive Committee of Council had referre letter from the Group to the Central Committee for Contr Practice for consideration. The Group wished to have appoin an *ad hoc* committee to investigate the relationships between profession and the Benefit Societies and the remuneration p to general practitioners and specialists. It was felt that committee should include representatives of the profession w experience of Benefit Society work, representatives of the Ben Societies and assistance of an actuary and a legal adviser. It stated that the Committee had agreed not to recommend Council that such a committee be appointed, as these were mat which should be dealt with by the Branches. Council *AGRE*

94. *Mines Benefit Society—Urological Appointments:* It reported that this matter had been referred to the Commi by the Executive Committee of Council. Temporary arrangeme had been made to fill these appointments, and at the end of trial period it was hoped to prove to the Society that the *per cap* fee adopted by Federal Council would have to be paid and t the number of appointments would be justified. The Commi recommended to Council that the Society should conform to 1/6d. *per capita* rate laid down by Federal Council and th failing this, the posts for urology should be banned.

Mr. Wolfowitz proposed 'That Council approves the urologi appointments to the Mines Benefit Society on the basis of 1 *per capita*, provided that the 1 in 10,000 rule applies.' On be put to the vote, this was *CARRIED*.

Mr. McMurray proposed that this resolution be qualified by

ion of the words 'for a limited period'. On being put to the this was *LOST*.

letter from Mr. C. T. Moller on the subject of Mines Benefit ty appointments was considered. It was proposed by Dr. piro, seconded by Dr. Gluckman and *RESOLVED* 'That in opinion of Council a specialist accepting an appointment to nefit Society should undertake to do the work himself.' It further proposed by Dr. Shapiro, seconded by Dr. Gluckman *RESOLVED Nem. Con.* 'That Council notes the contents Mr. Moller's letter and approves and commends the action h he has taken.'

Membership Figures: Figures were supplied for the number embers and dependants of 123 Societies out of a total of Council *AGREED* that these figures be *NOTED*.

Questions regarding Contract Practice: Certain members d questions regarding (*a*) Medical Aid Fees for Intravenous apy involving Blood Transfusion; (*b*) The Printing Industry dical Aid Society, and (*c*) The Northern Medical Aid Society. Associate Secretary replied that these matters were still ving attention.

r. Vercueil then moved the adoption of the Report of the mittee, which was *CARRIED* with acclamation.

he Chairman of Council proposed a vote of thanks to Dr. cueil and his Committee for their work. This was accorded acclamation.

Council adjourned for lunch from 12.50 p.m. to 2.15 p.m.

n resuming, Dr. Sichel was in the Chair.

ECONOMICS OF MEDICAL PRACTICE

Sub-Committee on Economics of Medical Practice: The irman said that it was necessary to appoint a new Sub-mittee.

was proposed by Dr. Turton, seconded by Dr. Lewis Robertson *RESOLVED* that this matter be referred to the Executive mittee of Federal Council who should receive all the reports he Sub-Committee on the Economics of Medical Practice, that the Executive Committee then deal with the matter as thought best.

Report of Sub-Committee for Liaison with Dental Association outh Africa: It was reported that the Dental Association had osed that representatives of each Association should be ed to attend the Council meetings of the other Association, ew of the many points of mutual concern.

fter short discussion it was *AGREED* that decision in this rd should be left until the next meeting of Council.

Sub-Committee for Liaison with S.A. Nursing Association: ncil *NOTED* that there was no Report from this Sub-mittee.

Sub-Committee for Liaison with Pharmaceutical Society outh Africa: Council *NOTED* that there was no Report from Sub-Committee.

Report of Sub-Committee on Medical Education and nships: A report from this Sub-Committee was submitted. Convener, Mr. McMurray, stated that he was expecting to ve further information and that he hoped to submit a more rehensive report to the next meeting of Council which would de reference to the function of the intern in the hospital. TED.

Amendment of By-Law 58: Notice of Motion had been n at the previous meeting of Council over the names of Dr. Shapiro and Dr. M. Peskin, that the second and third graphs of the By-Law be deleted and that the following be tituted therefor:

'The Head Office and Journal Committee shall have power to deal with all matters affecting the administration of the *Journal* and Head Office, provided that without the prior consent of the Federal Council or of the Executive Committee the Head Office and Journal Committee shall not—

(*a*) incur any extraordinary expenditure, or

(*b*) determine or vary the salary scales, remuneration or allowances of any official whose total remuneration exclusive of allowances exceeds £1,000 per annum, or

(*c*) mortgage, sell or purchase any immovable property on behalf of the Association.'

his motion was put to the vote and *CARRIED Nem. Con.* ouncil *NOTED* that this amendment would now be referred the Branches and would be placed before the next meeting of ncil for decision.

Health Services:

104. *Cape:* A Report was submitted, in which it was stated that there had been only one meeting of the Liaison Committee since the last meeting of Council. This had taken place on 22 August, 1956.

105. *Honorary Staff:* It was reported that there were further evidences of the breaking down of the honorary system in the Cape hospitals, and requests were being received for the appointment of more and more part-time and full-time medical staff. In view of the resolution taken at the last meeting of Council, the Association's representatives on the Liaison Committee had indicated that such appointments would not meet with any opposition from the Association if they were essential to the proper service of the hospitals concerned. *NOTED*.

106. *Shortage of Radiographers:* Attention had been drawn to the fact that there was a shortage of radiographers in the Cape hospitals. The shortage was admitted and it had been indicated that as much as was reasonably possible was being done to overcome the shortage. The wastage through marriage was quite considerable and although radiographers were encouraged to immigrate to the Union there were not enough to go round. It was admitted that there was delay in making appointments of both radiographers and medical personnel, and an attempt was being made to shorten this period. *NOTED*.

107. *Transvaal:* A Report was submitted, containing a summary of the matters which had been considered by the Augmented Executive Committee in the Transvaal since the last meeting of Council. These were dealt with seriatim:

108. *Interns at Baragwanath Hospital:* It was reported that the Augmented Executive Committee had received a complaint from the non-European interns and housemen at the Baragwanath Hospital that Indian and Coloured interns received four-fifths and Africans only three-fifths of the salary paid to Europeans. This salary scale applied only to the Transvaal as interns received the same salary in other Provinces. Representations had been made to the Medical Director of Hospital Services in the Transvaal on this matter, and the position was now that it was to be discussed at an inter-Provincial conference.

Council *NOTED* that this matter was still receiving attention.

109. *Multiple Hospital Appointments—Thoracic Surgeons:* It was stated that at the last meeting of Council it had been reported that the Medical Director of Hospital Services had undertaken to make a full investigation of this matter and to submit a report on it to the Committee. Dr. Hugo had now stated that it had been impossible for him to carry out this investigation, but had undertaken to report to the Augmented Executive Committee when this had been done.

This was *NOTED* by Council.

110. *Decentralised Clinics:* A letter from the Director of Hospital Services in the Transvaal was submitted, in which it was stated that it was not the intention of the Administration that the decentralised clinics should in any way interfere with the practice of private medical practitioners and that the Ordinance provided that patients attending the clinics should only be treated on the recommendation of private recommending officers. It was further stated that the Administration would take every possible step to ensure that the provisions of the Ordinance were carried out without laxity. *NOTED*.

111. *Medical Ethics Conference:* It was reported that a sub-committee of the Augmented Executive Committee hoped to arrange meetings between representatives of the S.A. Institute for Medical Research and the Pathological Departments of the Universities with representatives of the Association, in order that outstanding problems could be considered. *NOTED*.

112. *Appointment of Assistant Secretary in Transvaal:* The opinions of the Augmented Executive Committee on this subject were reported.

Short discussion followed and it was *AGREED* that the Assistant Secretary should be resident in Johannesburg in the first instance and that the Augmented Executive Committee would make a further recommendation in the light of experience.

113. *Retiring Age of Part-time Staff—Hospitals Service:* It was reported that the Augmented Executive Committee had considered a request from the Association of Surgeons that the retiring age of part-time hospital staffs should be 60 years and not 65 years as it seemed might become the policy of the Provincial Administration. It was stated that the Augmented Executive Committee considered that the retiring age should be 60 years.

It was proposed by Mr. Wolfowitz, and Council *AGREED*, that the retiring age should be 60 years.

114. *Hospital Appointments—District Surgeons:* It was reported that a letter had been received from the Director of Hospital Services in the Transvaal with regard to the appointment of district surgeons as honoraries in Provincial hospitals. The Augmented Executive Committee now referred this question to Federal Council for decision.

After short discussion it was proposed by Dr. Turton, seconded by Dr. Shapiro and *RESOLVED* that district surgeons should not be allowed to become honoraries at Provincial hospitals.

115. *Natal Augmented Executive Committee:* Dr. Grant-Whyte said that there was nothing to report at this stage but that it might become necessary to ask the assistance of Federal Council in the problem of decentralised clinics for non-Europeans *NOTED*.

116. *Orange Free State Augmented Executive Committee:* Council *NOTED* that there was no Report from this Committee.

117. *S.A. Medical Congress, Durban, 1957:* Dr. Disler, one of the Organising Secretaries of the Congress, reported. On behalf of his Branch he thanked Council for having elected Dr. Grant-Whyte as President-Elect. He went on to say that arrangements were well in hand and that they expected to have a successful Congress next year. He expressed his thanks to the Secretary and to the staff of the Head Office for the assistance and advice given in connection with the Congress. *NOTED*.

Matters Referred to or by S.A. Medical and Dental Council:

118. *Rules regarding Registration of Specialities of Medical Practitioners and Dentists:* Correspondence and memoranda on this subject were submitted.

It was proposed by Dr. Black, seconded by Dr. Shapiro and *RESOLVED* that the correspondence be referred to all Branches for opinion regarding the draft rules for specialists.

Council also *AGREED* that permission be sought from the Medical Council to publish the draft rules in the *Journal* for general information and to state that the Medical Council would be pleased to receive the views of individual practitioners as well as the Association's Branches. It was further *AGREED* that the opinions of Branches should be referred direct to the S.A. Medical and Dental Council before 31 December, 1956.

119. *Amendments to Medical, Dental and Pharmacy Act:* A Report by the Secretary on this subject was submitted, and reference was made to a letter from the Pharmaceutical Society of South Africa regarding a proposed conference.

It was proposed by Dr. Impey, and Council *AGREED*, that such a conference was desirable and that steps should be taken to make the necessary arrangements. Council further *AGREED* that its representatives at such a conference should be the members of the Augmented Executive Committee in the Transvaal together with the Chairman of Council, Dr. Vercueil and the Secretary of Council.

Matters Referred to or by Branches:

120. *Reduction of Accounts:* A letter from the Cape Western Branch was submitted, containing a resolution reading: 'That it be considered unethical, when rendering an account, to offer a reduction in the amount as an inducement to early payment of the said account.'

Council *AGREED* that this practice should be considered unethical and that the Cape Western Branch should be so informed.

121. *Immunisation Against Tetanus:* A letter from the Cape Western Branch was submitted, in connection with compulsory active immunisation against tetanus.

The Secretary stated that the Executive Committee had recommended that the opinions of the Paediatricians' and the Medical Officers of Health Groups be sought before discussion at the next meeting of Council. Dr. de Villiers said that this was not necessary as there were no grounds for asking for mass immunisation against tetanus.

Council *AGREED to NOTE* the letter.

122. *Group Areas Act:* Correspondence on this subject was submitted from the Cape Western Branch, the Southern Transvaal Branch and the Border Branch.

After short discussion Council *AGREED* that the whole question be referred to the Parliamentary Committee for such action as might be necessary.

123. *Boundaries of East Rand Branch:* The Secretary stated that he had received a letter from the Honorary Secretary of Branch since the Agenda had been sent out, in which it requested that this item should be withdrawn. Council *AGRE*

124. *Training of Midwives:* A Report was submitted by Secretary, in which it was indicated that this matter had origi been raised by the Natal Inland Branch. The Branch had unwilling to accept the opinion of the Executive Committe the Obstetricians' and Gynaecologists' Group and had sugge that the whole question be referred to a general meeting of Group. This had been done and the general meeting had confir the opinion of the Executive Committee.

Council *AGREED to NOTE* this report.

125. *Status of Hypnosis in Medical Treatment:* A letter f the Southern Transvaal Branch was submitted.

The Secretary reported that this matter had been referre the British Medical Association which had appointed a sp committee to consider the whole question. The report of committee had been published in the *British Medical Jou* The Secretary read extracts from this report and stated that matter had also been referred to the Psychiatric Group. referred to a letter from the Honorary Secretary of the Group which it was stated: 'Hypnosis is a recognised form of the in modern medical practice, and there is nothing to bar any me practitioner from including hypnosis in his therapeutic meth It was to be noted that under no circumstances would a me practitioner be permitted to associate himself profession with a lay hypnotist either by referring patients to him or discus patients and their problems with him.

It was pointed out that hypnosis was already recognised by Association in the fact that a fee for this procedure was inclu in the Tariff of Fees for Medical Aid Societies.

Council *AGREED* that hypnosis was a recognised form therapy and, if used by a medical practitioner, it was reason that he should charge for his services.

126. *Telephone Consultations:* A letter from the South Transvaal Branch was submitted, together with a reply from Secretary setting out personal opinions in this regard.

After discussion Council *AGREED* that the opinion of S.A. Medical and Dental Council should be sought regarding ethics of this matter.

127. *Circulars to Branches:* A letter from the South Transvaal Branch was submitted, in which it was requested sufficient circulars sent to Branches by the Head O should be supplied to each Branch to enable distribution to the members of Branch Council.

The Chairman pointed out that this procedure would inv both time and expense.

It was proposed by Dr. Gluckman and *RESOLVED* that matter be referred to the Head Office and Journal Committee consideration.

Matters Referred to or by Groups:

128. *Retiring Age of Medical Women:* A letter was submi from the S.A. Society of Medical Women, containing a resolu reading: 'The S.A. Society of Medical Women requests Fed Council to ascertain from the Public Service Commission whet any steps have been or are being taken to raise the retiring of medical women in Government and Provincial employ. In event of no steps being taken, Federal Council is requested ask the Public Service Commission to give consideration to point.'

The Secretary stated that the Executive Committee had agr to recommend to Council that a suitable recommendation made to the Minister of Health and to the Public Service Comm sion.

Council *AGREED* to the recommendation of the Execut Committee.

129. *Married Women in Permanent Posts:* A letter was submit from the S.A. Society of Medical Women, containing a resolut reading: 'The S.A. Society of Medical Women requests Fed Council to ascertain from the Public Service Commission whet any steps have been or are being taken to change the exist regulations re the employment of married medical women permanent Government and Provincial posts. In the event no steps being taken, Federal Council is requested to ask Public Service Commission to give consideration to this poi

The Secretary stated that the Executive Committee had agr to recommend to Council that a suitable recommendation

le to the Minister of Health and to the Public Service Commis-

ouncil *AGREED* to the recommendation of the Executive mittee.

30. *Amendments to Constitution of S.A. Society of Medical nen:* Certain proposed amendments to the Constitution of Group were submitted, and Council *AGREED* that these eferred to the Executive Committee for action.

31. *Obstetricians' and Gynaecologists' Group—Affiliation with national Federation of Gynaecologists and Obstetricians:* A r was submitted from the S.A. Society of Obstetricians and aecologists, in which it was requested that Council agree to amendment of the Group's Constitution to include affiliation the international body.

he Secretary stated that the Executive Committee had agreed ecommend to Council that affiliation be approved. Council REED.

32. *Training of Chemists for a Diploma in Biochemical Analysis:* tter from the Pathologists' Group was submitted, drawing tion to the proposed training of pharmaceutical chemists for loma in biochemical analysis.

r. Gluckman stated that he felt that this matter did not fall in the province of the Federal Council, as it was more a ter of the encroachment by one medical auxiliary upon another e of auxiliary.

ouncil *AGREED* that the matter be *NOTED.*

ellaneous:

33. *Artificial Insemination:* A letter was submitted from the National Council for Child Welfare, containing a resolution ing: 'That in view of the fact that the question of artificial mination deals with a highly technical and involved matter, Federal Council of the Medical Association of South Africa requested to cause investigation to be made into the subject n the medical, legal and religious aspects.'

fter discussion it was proposed by Dr. Impey, seconded by Shapiro and *RESOLVED:* 'That Federal Council understands that the South African courts have never been called upon to consider the legal implications of artificial insemination. In the opinion of the Federal Concil there is nothing unethical in artificial insemination from husband to wife. There may, however, be serious legal, ethical and religious complications in cases of artificial insemination from a man who is not the husband of the woman, and the Council feels that it is not its function to comment on these aspects.'

Other Business:

134. *Johannesburg Society on Alcoholism:* A letter was submitted from the Southern Transvaal Branch, covering a letter requesting representation by the Branch on the Johannesburg Society on Alcoholism.

Council *AGREED* to defer consideration of this matter until its next meeting.

135. *Date and Place of Next Meeting of Council:* On behalf of the Southern Transvaal Branch Dr. Agranat invited Council to meet in Johannesburg.

Council *AGREED* that next meeting be held in Johannesburg at a time to be arranged by the Executive Committee.

136. *Thanks:* Dr. Impey proposed a vote of thanks to the Chair and said he was sure that everyone would congratulate the Chairman for the able manner in which he had conducted the meeting. A vote of thanks to both Dr. Sichel and Dr. Struthers was *accorded with acclamation.*

Dr. Grant-Whyte proposed a vote of thanks to the Cape Western Branch for the hospitality which it has extended to the Council. This vote of thanks was *accorded with acclamation.*

The Chairman thanked Council for its vote of thanks to the Chair, and Dr. Owen-Smith replied on behalf of the Cape Western Branch.

Dr. J. S. du Toit proposed a vote of thanks and appreciation to the Secretary, the Associate Secretary, the stenographers and the ladies from the Head Office who had served refreshments. *Acclamation.*

The meeting ended at 6.10 p.m.

PASSING EVENTS : IN DIE VERBYGAAN

iliasis. An international symposium on moniliasis was held 29-31 October 1956 at Montevideo, Uruguay, under the auspices he local Faculty of Medicine and Institute of Hygiene. Moni- s has become increasingly prevalent with the widespread use ntibiotics. At the symposium the use was discussed of a new called Nystatin, which was developed in the laboratories of Health Department of New York State and perfected by one he leading pharmaceutical companies. In its curative use the is reported to have proved effective in over 90% of certain s of moniliasis, and it has a preventive value when given ng antibiotic therapy.

* * *

next meeting of Research Forum, University of Cape Town, be held at 12 noon on Tuesday 6 December 1956 in the A-Floor ure Theatre, Groote Schuur Hospital, Cape Town. Speaker: C. Merskey (in collaboration with Professor N. Sapeika, C. J. Uys and Dr. B. Bronte-Stewart). Subject: Experimental oma and blood coagulation.

* * *

Maurice Hurwitz, M.B., Ch.B. (Edin.), D.M.R.D. (R.C.P. & S.), formerly at the Diagnostic X-ray Department, Hammer- th Hospital (Postgraduate Medical School), London, and the umoconiosis Bureau, Johannesburg, has joined Drs. Loots, r and Esterhuizen in radiological practice at 101 Medical tre, 209 Jeppe Street, Johannesburg.

* * *

Stephen Eisenhammer, F.R.C.S., of Johannesburg, has been ted by the International College of Surgeons to represent th Africa in the section of proctology of that institution, has accepted the invitation. The International College of geons was founded in Geneva, Switzerland, and is incor- porated in Washington, USA. The countries at present represented in the proctology section are Canada, Thailand, Philippines, Mexico, Brazil, Argentina, Columbia, Puerto Rico, Cuba, Sweden, Japan, Spain, Israel and Beirut.

* * *

Mr. J. M. Edelstein of Johannesburg has been invited by the University of Liverpool to act as External Examiner in the 1956 examinations for the M.Ch. Orth., and will be leaving for Britain on a short visit at the end of November.

* * *

The Minister of Health, under section 3 of the Food, Drugs and Disinfectants Act, No. 13 of 1929, has appointed as pathologists Professor James Barnetson and Dr. J. N. Coetzee, whilst on the staff of the Institute of Pathology, University of Pretoria.

* * *

Union Department of Health Bulletin. Report for the 7 days ended 25 October 1956.

Plague, Smallpox: Nil.

Typhus Fever: Three (3) native cases in the Cradock district and two (2) native cases in the Cradock native location. Diagnosis based on clinical grounds only. One (1) native case out of three (3) reported in Bulletin No. 42 has been confirmed by laboratory tests as negative.

Epidemic Diseases in Other Countries.

Plague: Nil.

Cholera in Calcutta (India); Chittagong (Pakistan).

Smallpox in Rangoon (Burma); Bombay, Calcutta, Cuddalore, Madras, Pondicherry, Tuticorin, Visakhapatnam (India); Dacca (Pakistan); Nairobi (Kenya).

Typhus Fever in Baghdad (Iraq).

REVIEWS OF BOOKS : BOEKRESENSIES

POLIOMYELITIS

Poliomyelitis. Second Edition. By W. Ritchie Russell. Pp. xi + 147. 16s. net. London: Edward Arnold (Publishers) Ltd. 1956.

Contents: Preface to First Edition. Preface to Second Edition. I. Introduction. II. Infectivity, Quarantine, Epidemiology and Prevention. III. Clinical Features of the Disease. IV. Physical Examination. V. Factors which Influence Cell Vulnerability. VI. Management of Treatment. VII. Treatment of Bulbar Poliomyelitis. VIII. Management of Intermittent Positive Pressure Artificial Respiration (I.P.P.R.). IX. Treatment of Respiratory Paralysis in Spinal Cases. X. Care of Muscles and Joints. XI. Convalescence and Rehabilitation. XII. Physiotherapy. XIII. Future Prospects. References. Index.

The first edition of this admirable monograph could hardly have been more unfortunately timed. Published in 1952, it missed the fantastic poliomyelitis-epidemic in Denmark that year and the classic advances emanating from it—particularly in the treatment of respiratory failure by tracheotomy and intermittent positive pressure respiration. This second edition not only corrects this unavoidable omission but includes the newest research, in which the author himself figures so prominently.

The book, attractively written and well illustrated, adequately covers the subject in a scientific and practical manner. Thus, the aetiological factors dealt with include those which provoke or aggravate paralysis during or before the 'few critical hours or days'. They merit close study by education authorities in order that school children may avoid strenuous exertion such as athletics and swimming when poliomyelitis is rife. The biphasic character of the clinical features are lucidly described, and actual cases are briefly presented to bring home typical and atypical symptoms to the reader. The recommended examination aims at diagnosis with the least disturbance of the patient at a time when this may aggravate paralysis.

The attention paid to management of the disease is perhaps the book's most valuable attribute. The precise description of treatment of the acute stage covers the care of paretic and paralytic muscles, bulbar paralysis, and respiratory paralysis of spinal type. In addition to the use of the best types of 'iron lung', both the cuirass-type respirator and the 'rocking bed' appear to merit a place in treatment. The treatment of the dreaded combined bulbar and respiratory paralysis by the new intermittent positive-pressure respiration (Copenhagen method) using the Oxford bellows and the Radcliffe respiration-pump is described in detail and well illustrated. Finally, the chronic stage is well treated, including the best means of securing the psychological and physical rehabilitation of the patient.

It is impossible to overrate the importance of this timely 'great' little book and the only criticism can be that there is not enough of it. Its value is greatest to the officer responsible for the treatment of the acute phase of the disease, but it is of no less interest to the health officer, the physician and the orthopaedic surgeon. Indeed, no medical practitioner can afford to be without it.

H.R.A.

MEDICAL WRITING

Medical Writing. MD International Symposia No. 2. By Walter C. Alvarez—Hugh Clegg—Felix Marti-Ibanez—Hans Selye—Henry E. Sigerist. Pp. 66. New York: MD Publications, inc. 1956.

Contents: Thoughts on the Physician's Writing and Reading, By Henry E Sigerist. How Not to Write a Medical Paper, By Hans Selye. An Editor's Prejudices, By Hugh Clegg. Medical Writing, By Walter C. Alvarez. Books in the Physician's Life, By Felix Marti-Ibanez. Biographical Notes on the Contributors to the Symposium on Medical Writing.

The five distinguished authors whose essays appear in this little volume give their views on how physicians should write papers, and give advice on medical reading-matter in general. Sigerist considers clear thinking and command of the language in which one writes as the two prerequisites for good writing. Also the colloquial words used in a lecture must be avoided in writing. It is generally recommended that scientific papers should be short and factual, but this can make dull reading. In another paper Selye covers many aspects of the writing of articles from the point of view of possible mistakes in scientific reasoning; the article is written in Selye's own style. The editor of the *British Medical Journal*, H. Clegg, reveals the harassing, exacting, wo ing and ungrateful job an editor has, and the quality he ne He indicates the desirability of clarity, lucidity, simplicity brevity in medical writing—qualities that are rare. He stre the necessity to distinguish between the spoken and the wri word. Alvarez makes practical suggestions for the benefit of reader and how his attention may be caught and held by writer. Good summaries are obviously important, and he wo like to see them at the beginning of articles. The last in the b is a fine essay by Marti-Ibanez dealing with the reading expe of a physician and how he may because of this and his medic training very well become a great writer.

N.S

UROLOGY FOR GENERAL PRACTICE

Clinical Urology for General Practice. By Justin J. Cordonn M.D., F.A.C.S. Pp. 252. 47 Illustrations. South African P £2 17s. 6d. St. Louis: The C.V. Mosby Company. 1956.

Contents: I. Steps for Urologic Diagnosis. II. Obstructive Uropathy. III. plasms of the Genitourinary Tract. IV. Infections of the Genitourinary T V. Renal Failure. VI. Urinary Calculi. VII. Neurogenic Bladder Dysfunc VIII. Senescence, Fertility, and Impotence in the Male. IX. Injuries o Genitourinary Tract. X. Female Urology. XI. Congenital Anomalies.

To the best of my knowledge there is no text-book of urol suitable for undergraduate students or general practition wishing to refresh themselves in this subject. This book in view certainly fills this hiatus admirably.

Urology admittedly is a subsection of surgery, and for medical student it is dealt with in the ordinary surgical lect and tutorials. It is my experience that the average student scant benefit from his tuition in urology, owing (*inter alia*) overcrowding of the medical syllabus and lack of interest in special branch of surgery. A probable contributing cause is fact that a short, concise and readable book has not been availa

This Clinical Urology for General Practice is a relatively sm book of some 250 pages printed in bold print with clear chap and paragraphs. It covers the field of urology for students general practitioners completely and gives an up-to-date acc of modern methods of treatment. The text is beautifully illustra throughout with well-chosen photographs and X-ray reproducti The book has made such a good impression on me that I hesi to voice a few minor criticisms, and especially when such critic is a matter of opinion. The Thorek two-stage operation undescended testis which is recommended by the author is regar as a poor method of surgical treatment by a British school. S differences of opinion can readily be rectified by the tutor do not really detract from the great value of this book for medi students.

I have no hesitation in recommending this book highly to gen practitioners wishing to rejuvenate their knowledge of urol but particularly to medical students who suffer with urology, to their tutors burdened with the duty of teaching the subj

P.J.M.

A BOOK FOR EXPECTANT MOTHERS

Preparing for Motherhood. By Samuel R. Meaker, M.D. 196+19 Illustrations. $2.00 post paid. Chicago: Year B Publishers, Inc. 1956.

Contents: I. So you're Going to Have a Baby. II. How Do You Know It's True? III. Later Signs of Pregnancy. IV. What is Going on in Your B V. Some Interesting Predictions. VI. Your Doctor Takes Charge. VII. Care You Should Give to Yourself. VIII. The Food That Is Best for Your B and You. IX. Watch Your Weight! X. Common Discomforts, and Ways Relieve Them. XI. Some Troubles That Need Prompt Attention. XII. P and Preparations. XIII. The Arrival of the Baby. XIV. Ways of Making Ch birth Easier and Safer. XV. The Care You Will Need in the Next Few Wee XVI. Breast Feeding. XVII. The New Member of the Family.

This is one of the best books of its kind one has come acr It is in fact a miniature text-book of midwifery written for intelligent laywoman (and layman!).

The language is simple and the style easy. The author ma it clear that the purpose of the book is not to replace the doct instructions but that it should be read as a sort of home wo When there may be differences between the recommendation

the patient's doctor and those of the author 'in such matters follow his (the doctor's) advice unhesitatingly'. There is in fact very little about which the average practitioner will disagree. About the risk of having a baby Professor Meaker states: 'I'm sure that it is less dangerous to produce a baby than to drive an automobile daily over a period of nine months.' The chapters on Diet and Weight Control in pregnancy are a treat to read, if one may single out any in such a wellwritten series.

This book should find a wide appeal and may be recommended to patients with confidence. Perhaps one may be so bold as to suggest that midwives, medical students and even doctors, will glean very useful information from this excellently produced little manual.

E.M.S.

PAIN IN CANCER

Management of Pain in Cancer: Edited by M. J. Schiffrin, Ph.D. Pp. 245. $4·50. Chicago: Year Book Publishers Inc. 1956.

Contents: I. Systemic Analgetics by M. J. Schiffrin and E. G. Gross. General Considerations. Nonaddicting Drugs. Addicting Drugs. Adjuncts and Miscellaneous Agents. II. Nerve Blocks for Pain in Malignancy, by Max S. Sadove and Reuben C. Balagot. Principles of Nerve Blocking. Different Types of Blocks and Technics. Agents Used for Blocks. Blocks for Different Regions. Premedication. Reactions to Local Anaesthetics. III. Neurosurgical Aspects of Pain Management, by Oscar Sugar. Peripheral Nerve Section. Cranial Nerve Section. Nerve Root Section. Spinothalamic Chordotomy. Spinothalamic Tractotomy. Stereotaxic Lesions. Frontal Leukotomy. Miscellaneous Procedures for Relief of Pain. Neurosurgical Aspects of Pain by Region. IV. Humoral and Chemical Palliation of Malignancy, by Samuel G. Taylor, iii, and M. J. Schiffrin. Clinical Management of Malignancy. Pharmacologic Properties of Hormones and Drugs. V. Surgical Procedures in Control of Pain in Advanced Cancer, by Henry Schwarz, ii General Considerations. Specific Situations Requiring Surgical Intervention. VI. Radiation Therapy in the Relief of Pain in Malignant Disease, by J. W. J. Carpender. Radiation Combined with Chemotherapy and Surgery. Prevention of Pain. Quality of Radiation. Artificial Radioactivity. Metastatic Disease and Local Extension. Other Complications. Radiation Sickness. VII. Psychological Aspects of Pain in Terminal Malignancies, by V. Richard Zarling. General Considerations of Pain. Mental or Psychological Factors in Pain. Modification of the Pain Reaction Pattern by Psychological Support. Modification of the Pain Reaction Pattern by Hypnosis. Index.

The misery and suffering which invariably dominates the terminal lingering months of malignant disease, is a problem which is always with us, and one which concerns most members of the medical profession and, in particular, the general practitioner; for it is usually he who has to see the patient through this trying period.

This is an important field of medicine and one which unfortunately has been neglected far too much by the profession. The authors are to be congratulated for having chosen this aspect of cancer management as their subject and, in addition, they are to be commended for their very excellent production.

The 7 chapters are well written, easily readable and right up to date, and they cover pretty well every aspect of malignant disease in its incurable stages.

Chapter 1 discusses fully both the non-habit-forming and the habit-forming analgesics, and is full of valuable practical information. Special mention is made of 'maximum analgesic intensity', an important property of all narcotics, but one not generally appreciated sufficiently. In this respect, too, a warning is sounded on the ease with which drug addiction is produced, especially in protracted cases, and then the additional misery of addiction is superimposed upon an already miserable existence.

Nerve-blocking procedures are discussed in detail both as regards technique and the blocking agents—anaesthetic and necrotizing. Here too, we find an excellent assessment of the pros and cons of these numerous procedures in the many regions where they can be employed.

Nerve section is dealt with in another chapter where all the procedures, from peripheral nerve section under local anaesthesia, to the more complicated operations of chordotomy, tractotomy and leucotomy, are considered.

Palliation by means of hormones in carcinoma of the breast and prostate is dealt with in detail, and here the more recent operations of adrenalectomy and hypophysectomy are included. All the known chemotherapeutic agents used in the treatment of the reticuloses are discussed in some detail, and mention is made of more recent substances not yet fully explored.

All too frequently malignant disease is discovered when it is beyond cure, but the patient's existence can be made tolerable and reasonably comfortable by means of palliative surgery. The authors have appropriately included this aspect of terminal cancer and a wide range of this type of operation is critically discussed. Such operations often require considerable judgment and careful assessment in the individual case so that the patient is not left worse off than he was before. This chapter should be a useful guide to the physician.

Xirradiation is dealt with briefly, and the more commonly used radio-active isotopes are discussed in some detail.

The book concludes with a discussion on the psychological aspects of pain in cancer and the occasional value of hypnosis.

There can be no question that the authors have succeeded in producing an excellent little volume which should be of considerable value to all members of the medical profession.

W.G.S.

RADIODIAGNOSIS

The Chest. A Handbook of Roentgen Diagnosis. By Leo G. Rigler, M.D. (Pp. 380, with 338 illustrations. Second edition. $8.00.) Chicago: Year Book Publishers, Inc., 1954.

Contents: Introduction. I. *Normal Observations.* 1. Normal Chest. 2. Physiology of the Respiratory Tract. II. *Pathologic Conditions.* 3. Diseases of Bronchi and Lungs. 4. Diseases of Mediastinum. 5. Diseases of Pleura. 6. Interpretation of Roentgenograms of Chest. 7. *Lungs and Bronchi.* 8. Pneumonia. 9. Lobar Pneumonia. 10. Cardiac Density in Pneumonia. 11. Atypical Pneumonia. 12. Bronchopneumonia in Childhood. 13. Acute Bronchiolitis. 14. Miscellaneous Types of Pneumonia. 15. Resolution in Pneumonia. 16. Atelectasis. 17. Emphysema and Bronchial Asthma. 18. Foreign Bodies in the Respiratory Tract. 19. Bronchitis; Bronchiectasis; Bronchial Obstruction. 20. Pulmonary Abscess. 21. Cysts of the Lung. 22. Pneumoconiosis. 23. Lipoid Pneumonitis. 24. Radiation Fibrosis. 25. Lung Fibrosis; Lungs and Pancreatic Fibrosis. 26. Interstitial Fibrosis; Nonspecific Hemosiderosis. 27. Pulmonary Mycoses. 28. Sarcoidosis. 29. Erythema Nodosum. 30. Pulmonary Tuberculosis. 31. Tumors of Chest. 32. Tumors of Chest Wall. 33. Bronchial Tumors: Benign Adenoma. 34. Bronchogenic Carcinoma: Tumor Mass. 35. Bronchogenic Carcinoma: Bronchial Obstruction. 36. Bronchogenic Carcinoma: Atelectasis. 37. Bronchogenic Carcinoma: Bronchography. 38. Bronchogenic Carcinoma: Inflammatory Changes; Abscess. 39. Carcinomatous Abscess: Body Section Roentgenography. 40. Bronchogenic Carcinoma: Bronchography. 41. Bronchogenic Carcinoma: Early Stage. 42. Nodules in the Lung. 43. Pulmonary Metastases. 44. Lymphoblastoma. 45. *Mediastinum.* 46. Thymus Gland Enlargement. 47. Thyroid Gland. 48. Lymphoblastoma. 49. Tumors. 50. Masses: Differential Diagnosis. 51. *Pleura.* 52. Thickening. 53. Thickening and Calcification. 54. Pleurisy with Effusion. 55. Effusion. 56. Pneumothorax. 57. Pneumothorax: Adhesions. 58. Hydropneumothorax. 59. Pneumothorax: Encapsulated. 60. Pleural Cavity: Opaque Mediums. 61. Tumors. 62. *Thorax:* Post-operatively. 63. *Lungs:* Post-operatively.

The new edition of this handbook maintains the high standard set by the original. The reproductions are excellent, and they are so numerous as to constitute an atlas. The descriptive part is for the most part concise and accurate. A wide field of radiological pathology in the chest is covered, and the section devoted to the relationship between pathology and radiology is particularly good. There is also much that is new.

A paragraph on the risks of diagnostic radiology has been added. This rather overstates the case, while there is no mention of the simplest precautionary measures. It is, however, an apt reminder for the general medical reader to whom this volume is directed. Rightful emphasis is placed upon the fact that 'a negative fluoroscopic study does not exclude pulmonary tuberculosis, . . . silicosis, . . . diffuse fibrotic lesions, . . . and its usefulness is largely related to the coarser lesions of the thorax'. The limitations of fluoroscopy are carefully considered.

Certain technical features of the previous editions such as the discussion on phototimers have rightly been omitted, but the brief dismissal of the water-soluble contrast media for bronchography does not reflect present practice, and is unjustified. The statement that the trans-crico-thyroid method is rarely used today reflects an experience that does not embrace the water-soluble contrast media, where a needle of narrow bore can be used with advantage. Figure 27 is not adequate for a modern bronchogram.

The reproductions are good, but it is a pity that reference from figure to text has been made so difficult, and some tabulation here would be advantageous, e.g. Figures 17-32, and others. The method of introducing new figures is good.

New chapters on arteriovenous aneurysm, erythema nodosum, nodules in the lung, etc. have been added. The value of bronchography in the diagnosis of primary lung-neoplasms is perhaps over-emphasized.

On the whole this handbook achieves its purpose—to provide a ready reference and a standard of comparison for the non-radiologist to use to review his knowledge of chest radiology. It is also likely to be of value to the radiology student, and possibly the radiologist.

H.J.

CORRESPONDENCE : BRIEWERUBRIEK

REPORT OF FEDERAL COUNCIL MEETING

To the Editor: I was astonished to read in the paragraph headed 'Proposed Sponsored Medical Aid Plan'[1] that it became necessary for Federal Council to go into committee on the above matter of vital concern to the profession and to the public, and to emerge from its *secret deliberations* with a mere statement that the Shapiro Committee had resigned and that the Executive should be left to carry on.

I can recall lengthy memoranda on medical economics submitted by the Committee to your *Journal* and Federal Council spending considerable amounts on obtaining expert information overseas. I can also recall meetings of the Southern Transvaal Branch in which this matter was discussed at full length, and a questionnaire being sent to doctors, from which an overwhelming response was received favouring a sponsored medical aid scheme.

I feel that the profession is entitled to have a full verbatim record of the proceedings, the reasons why the Shapiro Committee resigned, and whether the Executive intends taking any active and immediate steps to implement the plan proposed.

R. Polakow

Medical Centre
Jeppe Street
Johannesburg
2 November 1956

1. Report (1956): S. Afr. Med. J., **30**, 1042.

[The minutes of the Federal Council are published in this issue of the *Journal* (pp. 1114-1125)—*Editor.*]

RUBELLA AND PREGNANCY

To the Editor: Recently I have been asked to give an opinion on cases of pregnancy with alleged rubella infection. I am sure many of my colleagues have been in a similar position. At the moment, I am conducting a local survey.

While not going into the pros and cons of assessment, I should like to hear the opinions of your readers on the suggestion of giving gamma globulin to all women if the first antenatal booking is before the 12th week of gestation, and if there is no history, or a doubtful history, of having had rubella in the past. This would be especially applicable at the time of seasonal prevalence. In my opinion this procedure would be worth the trouble and expense.

James Miller

4 Western Road
Port Elizabeth
5 November 1956

CEREBRAL ANOXIA FOLLOWING ANAESTHESIA

To the Editor: There are several points we wish to raise with regard to Dr. Frances Ames's article[1] 'Cerebral Anoxia following Anaesthesia', which appeared in your *Journal* of 20 October 1956.

In our opinion it is wrong to state that 'many anaesthetists seem surprisingly casual about the danger of meddling with the circulatory systems of their patients'. Modern anaesthesia has become an exact science, based on definite physiological and pathological factors. To be casual about the state of the circulatory system would be to court disaster, and the prevention of anoxia is, and always has been, the main concern of the anaesthetist.

We agree with Dr. Ames that hypotensive anaesthesia should not be undertaken lightheartedly. There are definite indications for this type of anaesthesia, and it should be administered only by anaesthetists well versed and experienced in its technique. Under these conditions it is perfectly safe, and has numerous advantages both for the patient and the surgeon. Its safety is demonstrated by the fact that during the past 6 years we have used this technique in some 1,200 cases in the age-groups from 10 to 86 years without any fatality or a single operative or post-operative complication. We have also followed up our cases, and have failed to find any mental or personality changes, despite the fact that some cases had several hypotensive anaesthetics. Dr. Ames is therefore wrong in suggesting that dementia is a common sequel to hypotensive anaesthesia.

We do not agree with the statement that 'a bloodless field . . . is also an anoxic field'. Excluding the use of a tourniquet or hypotensive anaesthesia, a bloodless field is an indication of acute circulatory collapse, the resulting anoxia being due to the circulatory collapse. In induced hypotension a bloodless field is certainly not anoxic, and tests have shown that the oxygen concentration of the brain cells is normal during hypotensive anaesthesia. A field produced by anoxia is intensely congested and cyanotic, not bloodless.

As for the illustrative case report, we fail to see its relationship to the introductory remarks on modern anaesthesia, relaxants, hypotension, etc. In our opinion, it was not the agents used which caused the anoxia, but the inadequacy of the anaesthetist. After the use of 0·9 g. of thiopentone and 180 mg. of Flaxedil for induction, once cyanosis had manifested itself it was the bounden duty of the anaesthetist to ensure that the airway was clear, the tube properly in position, artificial respiration adequate, and the oxygen concentration increased—not to have waited for 15-20 minutes. The post-operative course in this case cannot be blamed on the drugs used, but on the mismanagement of the case.

H. Bentel
Lionel Melzer

403 Ingrams Corner
Kotze Street
Johannesburg
30 October 1956

1. Ames, F. (1956): S. Afr. Med. J., **30**, 1013.

TREATMENT OF FRACTURED RIBS

To the Editor: The time-honoured treatment of fractured ribs by strapping the affected side is uncomfortable and the strapping painful to remove. Some patients suffer an allergic reaction beneath the strapping, and in hot climates it appears to be most undesirable.

I can speak from experience, because some 20 years ago I was treated by the famous Dr. Woods of Cambridge—probably one of the greatest authorities on sports injuries in the world. He was an ex-Olympic champion at putting-the-shot and the experience of having my strapping ripped off daily by his powerful arms is an experience I should prefer to forget.

Treatment with a type of canvas jacket is inadequate and cumbersome.

An ideal form of treatment, which offers comfort with adequate support, is to measure the patient's chest on forced expiration, get some female relative to buy a cheap 'step-in' or 'roll-on', remove the suspenders from it, and slip it over the patient's head. This can be removed for bathing etc.

I have found this method most satisfactory. A 'step-in' can be bought for 6s. 11d.

Brennan De Vine

12 Medical Centre
31 Field Street
Durban
24 October 1956

THANKS TO DOCTORS

To the Editor: I am enclosing copy of a letter received from the Diocese of Pretoria, and should be very much obliged if you will publish it in the *Journal*.

The letter is as follows: 'I have much pleasure in informing you that the Diocesan Synod at its session held on 1 October 1956 adopted the following unopposed motion:

> 'That this Synod records its grateful thanks for the many services so willingly and freely given to the clergy and their families by the doctors of the medical profession; and that a copy of this resolution be sent to the Secretary of the Northern Transvaal Branch of the S.A. Medical Association.'

E. Fasser
Hon. Secretary
Northern Transvaal Branch

Administrative Building
General Hospital
Pretoria
31 October 1956